What you need to know about how depression works and how to beat it

in one easy to read ebook

by Mark Tyrrell and Roger Elliott

uncommon knowledge®

The Natural Depression Treatment Program

Uncommon Knowledge has published a Natural Depression Treatment Program based around the information in the Learning Path.

If you find the Learning Path helpful, you can read more about the practical program here.

The program contains 17 depression therapy sessions, published as an ebook, with 17 supporting audio sessions.

The whole program can be downloaded so you can get started right away.

Read more here…

IMPORTANT NOTICES

Contributions

If you know someone who you think would benefit from the Learning Path, please direct them to the website, rather than sending them the book. Thank you.

If you own a website and can link to http://www.clinical-depression.co.uk that will help us reach more people suffering from depression.

Thank you for any help you can give.

Theft

If you downloaded this ebook from anywhere other than www.clinical-depression.co.uk or www.uncommon-knowledge.co.uk, it is a stolen copy.

If this is the case, please let us know where you got it. Thank you.

Acknowledgements

Our thanks go first to our friend Michael McLean, for a tireless and inspired piece of work in organising the information for this site. If it wasn't for you Michael, it would never have happened.

Then to the Human Givens Institute, and particularly Joe Griffin and Ivan Tyrrell. Joe, who made the link between dreaming and depression, and in doing so did a huge service to psychology and depressed people the world over. And Ivan, without whom the invaluable work of the Institute would never have taken place.

And finally, though not least, to the hundreds of people who, though suffering from depression, have taken the time to let us know how much the Depression Learning Path has helped them. There is no better motivation.

Roger Elliott and **Mark Tyrrell**
Uncommon Knowledge Ltd

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Roger Elliott and Mark Tyrrell are directors of Uncommon Knowledge Ltd, a UK-based company providing training in psychotherapy, hypnotherapy, emotional intelligence and self help techniques. Since 1996 they have been helping individuals and professionals improve their ability to help themselves and others deal with a wide range of psychological problems ranging from clinical depression, anxiety disorders, panic attacks and OCD to self confidence, public speaking confidence, exam and driving test nerves and more.

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Uncommon Knowledge reaches more than a million people every year with psychological information that is clear, accurate and, above all, helpful.

The free online Depression Learning Path has helped hundreds of thousands of people understand depression better – and so take control. You can read some of their comments here.

"What you need to know about how depression works and how to beat it"

A word from the authors

If you suffer from clinical depression, the Learning Path will greatly improve your chances of beating it for good.

But to get rid of depression, and ensure it remains nothing more than a bad memory, you really need a complete understanding about what it is and how it works. That's what the Depression Learning Path is for.

We are excited to be able to share this information with you because, when we use it with our depressed patients, it is incredibly effective at helping them get rid of their depression. That's why we ask you to stick with us right through the Learning Path.

Here's a bit of feedback to motivate you!

A comment from a happy follower of the Learning Path

"I can say without exception that this is the best article I have EVER read about depression and how to beat it. And I have read many, having been a depressive for over 40 years!

"I sincerely wish that more people could be made aware of your site, by some kind of publicity – be it more links from more sites or something. Because I strongly believe that they too would be helped by following the Learning Path and would then have the knowledge required on how to get help with beating their terrible depression.

"So I implore you to publicise your site far more, so that it reaches far more people, because I think it's the most easy to follow, practical guide to beating depression I have ever read.

"I would like to thank everyone who contributed to your site and hope that millions of people will get to hear of it and be helped by it – which they would be, if they only knew it was there!"

Yours most sincerely, Sandra Brierley, Basildon, Essex.

(When Sandra wrote this in May 2002, the site had just been launched.) You can read more visitor comments here.

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One of the biggest obstacles to beating depression is the huge amount of inaccurate information in both popular culture and, amazingly, the medical profession. Therefore, a lot of what you read in the Learning Path may challenge your existing ideas about depression.

Before you embark on the Path, you should be fully aware that this information is for educational purposes only, to be used in a similar way that you would use a book in a library. Its creators are not medically trained, and it is **not intended to replace medical advice**.

By taking the Learning Path you will:

- learn the truth about antidepressants, and the truth about how effective they are
- find out what a major us government study recommends for the treatment of depression – the results may astound you, especially if you've seen a doctor or counselor
- protect yourself from damaging forms of therapy and counseling, and learn how to find a good therapist
- understand how depression works – it often makes people feel much better right away
- discover what you can do to help lift your own depression
- and much much more.

If you have problems with depression, the best way to beat it for good is to become an expert!

It can take as little as half an hour to complete the Learning Path, but go at your own pace and absorb the information in your own time. If you really are pushed for time and energy, jump to the most important part of the Path – Understanding Depression. When you've got a little more time and energy, go back to the beginning and work your way through, taking time over the sections that you find most relevant and helpful.

Wishing you all the best

Mark and Roger

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Your map of the Depression Learning Path

Below is an index to all the parts of the Learning Path. You will be returned to this index once you have completed the Path in case you want to review any particular section.

For now, we recommend you start at the beginning.

The Learning Path

Section 1
Depression Information

You'll start by getting a complete **overview** of all the relevant facts about depression. This will ensure you have an accurate picture as a **foundation** for the rest of the Learning Path.

Section 2
Understanding Depression
How Depression Works

Probably the most important part in **overcoming** depression, a clear **understanding** of how it works, and what it actually is.

Section 3
Treating Depression
Drugs and Psychotherapy

With all the available treatments out there, it's **vital** you can negotiate the **minefield** of drugs, therapies and counseling.

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Welcome to The Learning Path

Starting with the signs of depression, the Learning Path will take you on a journey during which you will learn astounding, revolutionary and vital facts about clinical depression. The aim is to give you up-to-date information on depression and what the research says is the best treatment. As you go along, follow the signs at the bottom of each page.

During your journey, you will learn:

- how therapists are now lifting even severe depression **quickly**
- the **astounding** new discovery that shows how depression is caused by over-dreaming, and what you can do about it
- why depression is 10 times more common in those born since 1945 than in those born before, and why this is important to you
- the **facts** about drugs vs. therapy for depression and much, much more.

Once you have completed the Learning Path, you will know enough about depression to decide on the best way for you to get rid of it, and stop it coming back.

So, onto the first section… the signs of depression.

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Depression information

Have I got signs of depression?

IF YOU have been feeling down, or out-of-sorts, your thoughts can easily turn to whether you are depressed or not. This first section will take you through the signs of depression and how depression is diagnosed.

However, whether you 'fit' the depression diagnosis or not is unimportant. If you are feeling so down that you need to do something about it, that is enough.

Usually, our clients report one or more of the following:

- Exhaustion on waking
- Disrupted sleep, sometimes through upsetting dreams
- Early morning waking and difficulty getting back to sleep
- Doing less of what they used to enjoy
- Difficulty concentrating during the day
- Improved energy as the day goes on
- Anxious worrying and intrusive upsetting thoughts
- Becoming emotional or upset for no particular reason
- Shortness of temper, or irritability

Not all people have all of these, and some have different signs, but if you are depressed, at least some of these will probably ring true with you.

The individual signs of depression – the way you feel – are what are used in diagnosing depression. So it's easy to see why there is so much confusion, seeing as the signs are generally common emotions and feelings.

There are also physical effects of depression, which we'll come to later.

Only a qualified doctor or health practitioner can formally diagnose you with clinical depression. However, how they reach this diagnosis gives an incredibly important insight into how to treat depression.

Depression screening and tests for depression

Screening for depression is becoming more common, as we begin to realize how much is left undiagnosed. So let's look now at how clinical depression is normally diagnosed.

Diagnosing depression

According to the definitions of most medical, psychological and psychiatric bodies, there is a commonality in the diagnosis of depression. Most depression tests have a very similar framework.

Almost without exception, clinical depression will be diagnosed if a certain number of feelings, that are signs of depression, are present over a certain period of time.

Below is the 'official' guide for diagnosing clinical depression:

A person can be diagnosed as suffering from clinical depression if:

(A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

(B) The symptoms do not meet criteria for a Mixed Episode.

(C) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(D) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

(E) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

[Source – Symptoms of Depression, PsychCentral]

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Depression – a natural response?

OK, so that's what the doctors use. But if we look at criterion E), it raises some interesting questions.

It says that clinical depression can be diagnosed if the symptoms cannot be attributed to bereavement. So, since grieving is a natural response, we can see that depression is simply an out-of-place natural response.

And of course it is. If it were not, we would have to take drugs to create it.

So what about the incredibly popular idea that depression is due to some unnatural chemical imbalance in the brain. That this 'imbalance' is the source and root cause of depression?

It's possible, but it just doesn't make sense for the majority of cases. And when we look at the increase in depression over the last 50 years or so, we will see that our brain chemistry just can't change that quickly.

KEY UNDERSTANDING

Most depression is not due to a chemical imbalance, or genetic factors. Low serotonin levels are a result, not a cause, of depression.

Despite the prevailing ideas for the last few decades, this is now known to be a fact. **(1)**

This misunderstanding is also the reason why drugs for depression miss the point, and treat the symptoms instead of the causes.

Understanding this is one of the keys to understanding depression itself.

Next, we'll look at the symptoms of depression and how they come about…

Notes

1 – Le Fanu. J. (1999) *The Rise and Fall of Modern Medicine*. Little, Brown & Company.

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Typical symptoms of depression

ALTHOUGH it is often classed as 'mental illness', clinical depression often has as many physical symptoms as mental. The feelings or emotions that are **depression symptoms** actually begin to cause the physical effects. How this happens is a vital part of understanding depression and the symptoms that come with it.

If you are depressed at the moment some of the following symptoms may sound familiar:

- You feel miserable and sad.
- You feel exhausted a lot of the time with no energy.
- You feel as if even the smallest tasks are sometimes impossible.
- You seldom enjoy the things that you used to enjoy – you may be off sex or food or may 'comfort eat' to excess.
- You feel very anxious sometimes.
- You don't want to see people or are scared to be left alone. Social activity may feel hard or impossible.
- You find it difficult to think clearly.
- You feel like a failure and/or feel guilty a lot of the time.
- You feel a burden to others.
- You sometimes feel that life isn't worth living.
- You can see no future. There is a loss of hope. You feel all you've ever done is make mistakes and that's all that you ever will do.
- You feel irritable or angry more than usual.
- You feel you have no confidence.
- You spend a lot of time thinking about what has gone wrong, what will go wrong or what is wrong about yourself as a person. You may also feel guilty sometimes about being critical of others (or even thinking critically about them).
- You feel that life is unfair.
- You have difficulty sleeping or wake up very early in the morning and can't sleep again. You seem to dream all night long and sometimes have disturbing dreams.
- You feel that life has/is 'passing you by.'
- You may have physical aches and pains which appear to have no physical cause, such as back pain.

It's this wealth of depression symptoms, and the broad scope that confuses many people as to what depression actually is. Explanations rarely cover all the symptoms, and everybody's experience is different.

The Learning Path will complete the picture for you. You will gain a complete understanding of depression that incorporates how we think, how depression affects our biology and where the physical symptoms of depression come from. We will come to that soon, but first a look at what causes depression.

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Causes of depression

THERE are 3 main points of view about the **causes of depression**. Most commonly held is the view that it is generally some combination of these three.

1. Depression is a medical disease, caused by a neurochemical or hormonal imbalance.
2. Depression is caused by certain styles of thinking.
3. Depression is a result of unfortunate experiences.

While each of these can be argued strongly to be a **cause** of depression, each also leaves many important questions unanswered. On the surface, each has a strong case, but none give us the complete picture.

Here are some important considerations:

- Although depression causes physical symptoms, and on rare occasions has physical causes, **it is not a disease**.
- A core aspect of depression is thinking styles, but does being a pessimist inevitably cause depression?
- Trauma, upheaval or sad experiences can seem to trigger depression, but why in people whose circumstances are similar, do some suffer from depression and others don't?
- How can your thinking style cause the horrific physical symptoms of depression? (This will be answered shortly)

Only when we consider all the aspects surrounding depression can we truly see how the pieces fit together, giving us a real understanding of the causes of depression, and therefore the best way to beat it.

By looking at the current thinking on these 'causes' of depression, we can piece together a true understanding of depression and explode some of the myths surrounding it.

1) On depression as a disease

As we have seen, depression is not a disease. The physical symptoms are just that, symptoms, and not causes.

Being depressed can feel like a physical disorder because you often feel exhausted, experience pain, have changes in appetite, and so on.

A key to understanding depression lies in looking at how the exhaustion and the physical effects of depression are caused by the link between emotionally arousing thoughts, dreaming and exhaustion. (More on this soon.)

2) Depression and thinking styles

It's fairly obvious that depression is not an inevitable consequence of things going wrong. Different people react to adversity in different ways, and this has led to the study of how depressed peoples' thinking styles compare to those who don't depress.

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We know that many people appear to have 'perfect lives' on the outside while being very depressed inside, often feeling guilty for being depressed as well – 'I should be happy' is the common thought.

Other people can have many external disadvantages and yet never become depressed. When dealing with depression, it is vital to understand that there are many ways of dealing with adversity, some of which will tend to cause depression, and others which will not.

3) Depression and events in our lives

A result of bad experiences?

Depression is often linked with bad experiences, but can events actually cause depression? If something awful has happened to you, of course you're going to feel sad, angry, hurt or in shock. And often, traumatic events can be linked to the onset of depression. This does not, however, mean they cause it.

IMPORTANT NOTE

Post traumatic stress disorder can lead to depression due to the continuing emotionally arousing thoughts it creates.

Quite apart from the results of having your life interrupted on an ongoing basis by horrific memories, the emotional arousal they create can cause depression.

(We will see how shortly.)

The link between what happens to a person and how they feel as a result depends on how they **relate** to it. That does NOT mean that people who become depressed are to be blamed, it simply gives us an insight into why depression occurs.

This is clear as we're all aware of people enduring the most horrible circumstances imaginable without becoming clinically depressed.

Events can be seen to be a trigger for depression, but depression is not caused by what happens to us in life (although every one needs a break sometimes). It's about how we respond and make sense of events.

Depression relies on how we explain things to ourselves

Much of clinical depression is about how we interpret reality. And when we start to develop depression symptoms, a depressive thinking style can seem impossible to break.

By understanding depressive thinking styles, we can begin to see how they form a pattern of thinking, a cycle of depression, that creates a downward spin and so continues to fuel the depression. We will look at how to break this cycle later in the Learning Path.

Now we'll look at some of the ideas around the medical causes of depression…

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Medical causes of depression

As we have seen, depression is not primarily a physical disorder, although it is often described as a 'disease'.

> "Depression, we are saying, is not a disease; it is a natural response to certain types of emotional introspection that result in excessive dreaming."
>
> *Human Givens*, 2003, J. Griffin & I. Tyrrell

Overcoming depression is made much harder by the many half truths that are commonly aired, on the news, in magazines, or by well-meaning friends. These often make it seem inevitable you'll get depression, or that once you suffer from depression you'll have it for life.

It's essential to understand that depression is much more than simply a disease or a chemical imbalance. The more we understand about the cycle of depression, that affects our mind and body, the better prepared we are to treat it.

Throwing some light on some of commonly claimed **'medical' causes of depression**, gives us a better understanding of depression, and therefore a better chance of overcoming it.

Depression as a disease

Depression can not be said to be a disease, because it is not primarily a biological disorder – that is, the root cause of the symptoms are not usually physical. How do we know? Well, here's one way:

> People born since 1945 are **10 times** more likely to suffer from depression than those born before.

That is an astounding figure, and cannot be explained away by people going to a doctor more, or depression being diagnosed more easily, as these were taken into account in the study.

Human biology doesn't change that quickly.

What it does show clearly is that most depression is non-biological. Depression has biological effects, but studies now show that less than 10% of depression is biologically caused.

The most widely accepted explanation for this sort of phenomenon is that society has changed. Over the past 5 decades, there has been:

- a breakdown in the extended family
- a dispersal of communities
- an increased focus on material wealth
- an overwhelming prevalence of news media
- and an increase in focus on 'the self'.

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All of which, and more besides, add up to a potent recipe for depression.

Changes to levels of neurochemicals

Clinical Depression is often said to be caused by a chemical imbalance in the brain, and this is what most drug treatments are based on. Certainly in many cases, there is a reduction in the amount of certain neurotransmitters found (monoamines such as serotonin and norepinephrine) in depressed people.

However, low serotonin levels are simply another symtom of depression, not a cause. The more negative introspection you carry out, and the fewer pleasure-giving activities you participate in, the lower your serotonin levels become.

> "Regarding depression as 'just' a chemical imbalance wildly misconstrues the disorder."
>
> *Psychology Today*, March, 1999

Drug therapies that work on this imbalance lift depression completely in a third of those who take them and partially in another third. For a third of people, antidepressants don't work at all, and many who do get positive results stop taking them because the side effects are worse than the depression symptoms they are supposed to be treating.

Antidepressants are also much worse at preventing relapse than appropriate psychotherapy (which is obvious, when you consider they are treating a symptom, not the cause of depression). **(1, 2)**

Depression can lead to chemical changes in the brain, which return to normal once your depression lifts.

Also, we are fully aware that clinical depression is far more than a prolonged sadness, or period of grieving. Yet these chemical imbalances can be found on occasion in all of these situations.

This is why depression is not caused by chemical imbalance in the vast majority of cases.

Hormonal imbalances

One 'medical' cause of depression often given is the overproduction of stress hormones.

The hormonal imbalances related to depression are to do with our natural reactions to stress, and stress and depression are certainly linked. But does this hormonal imbalance actually cause depression?

It is true that depressed people often have increased levels of stress hormones in their bloodstream **(3)**, but again, this is a symptom, not a cause.

When you ruminate, or introspect in a negative way, you create emotional arousal that causes the release of stress hormones. That night, in REM (dream sleep), you become emotionally aroused again as dreaming 'flushes out' the emotional arousal from your brain.

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That is why depressed people have higher levels of stress hormones, and also why you can wake up feeling exhausted. More on this later.

How can stress cause depression?

Although stress is a fairly "modern" concept in terms of our biology, the body deals with stress by viewing it as a traditional threat, for example being attacked.

To deal with stress, the body's natural "flight or fight" reactions kick in. Namely:

- shutting down nonessential or distracting activities
- enhancing delivery of "fuel" to the main muscles
- suppressing appetite for food and sex
- heightens alertness
- increasing levels of stress hormones such as adrenaline and cortisol

Obviously this state is not healthy for prolonged periods of time.

The actual link connecting depression and stress concerns our thinking styles, namely the "All or Nothing" thinking our mind uses when it feels we feel threatened.

KEY UNDERSTANDING

When you are stressed, your brain works differently. You are more likely to resort to 'All or Nothing' thinking, which causes catastrophising, and difficulties in solving complex problems.

In turn, this creates more arousal, or stress, and so continues the 'loop', increasing the amount you dream, and so exhausting you. This has an additional effect in the way it changes your sleep patterns, as you will see later in the Learning Path.

As we continue to discuss this, remember that statistics only give a general picture. Your own case is totally individual and you should not rule out any line of treatment. For now, your best weapon against depression is knowledge.

Next in the Learning Path, more on the myths surrounding the causes of depression…

Notes

1 – Teasdale, J. D. et al. (2000) Prevention of relapse/recurrence in major clinical depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 4, 615–23.

2 – Psychotherapy Versus Medication for Depression: Challenging the Conventional Wisdom With Data – David O. Antonuccio and William G. Danton, University of Nevada School

3 – Nemeroff, C. B. (1998) The neurobiology of depression. *Scientific American*, 278, 6, 28–35.

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Medical causes of depression (cont.)

HERE we look at what the research says about more of the so-called 'medical causes' of depression...

"Depression is hereditary"

"Depression runs in the family" or "It's in your genes" are commonly given as causes of depression.

If you are suffering from depression, being told you were "bound to get it", can be an incredibly unhelpful statement to have thrown at you. And it's not true.

There is *some* evidence that *some* depression has a genetic basis. Manic depression, or bipolar disorder, in particular.

However...

1. We know that most depression is learned, not genetic. **(1)**
2. Because much depression has to do with styles of thinking, behavior and interpersonal relationships, there is much scope for depressive styles to be passed down in families by learning. **(2)**
3. Even if you do have a genetic predisposition to depression, it is no more than a predisposition. You are not certain to become depressed, by any means. There is no gene for depression, and there never will be because genes just don't work that way. **(3,4)**

"It's in your genes"

We now know that most family depression is learned, not genetic. It's incredibly hard not to be affected by a depressed person, and as children, much of our behavior is learned from our parents. (See 2 & 3 above.)

"Depression is caused by illness"

Depression can "co-occur" or be triggered by an existing medical condition. The physical effects of depression are very real and often debilitating, but only around 10 – 18% of depression is triggered by another medical condition.

And as depressing as some diseases are, they don't automatically cause depression.

Pain, for example, can cause an inability to partake in enjoyable activities, interrupt sleep patterns, make life less pleasant, and cause feelings of hopelessness.

Some food allergies, or intolerance, when undiagnosed cause low energy levels, interrupted sleep, and increased worry as the person tries to figure out what is wrong with them.

However, they do not cause depression.

To understand the link between physical causes of depression, and depression itself, we need to first to look at the thinking styles associated with depressive behavior and symptoms. From here we can see how the these cause ongoing physical effects.

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This is where we get an important insight into understanding depression and how it is maintained.

This connection is in fact the cause of depression, and so it is crucial to understand when you are looking for help with depression. We will explore this fully later in the Learning Path.

Next we're going to look at the increase in teenage depression. This should be helpful even if you are not a teenager or don't have teenage kids…

Notes

1 – Yapko, M. D. (1997) *Breaking the Patterns of Depression*. Doubleday.

2 – Yapko, M.D. (1999) *Hand me down blues – How to stop depression from spreading in familes*. St Martin's Griffin.

3 – Papermaster, D. (1995) Necessary but insufficient. *Nature Medicine*, 1, 874–5.

4 – Le Fanu. J. (1999) *The Rise and Fall of Modern Medicine*. Little, Brown & Company.

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Teen depression – Why is it on the increase?

CHILDHOOD and teen depression is a reality. This is one of the most alarming facts to come from all the research; depression is affecting younger and younger people. **(1)** Here we look at why, and what we can do about it.

Twenty years ago depression in children was almost unknown. Now the fastest rate of increase in depression is among young people. Again, this backs up the fact that most depression is not caused by chemical imbalances, whether in teenagers or adults.

What we are seeing are changes in society where basic needs for companionship, healthy goals, responsibility, connection to others and meaning are not automatically met. Children and teens are fed a constant diet of images showing how we are meant to look, sound and be, and told that this is important in life. Meaning is attached to what they have, or look like, rather than what they do, or achieve.

Regardless of our own affluence, we see what those at the 'top' have and are told we should have it too, without thought for the tools or strategies to go about achieving it. During childhood, teenage years and particularly adolescence, pressure to conform with peers can be almost intolerably strong. If children feel different, inadequate or deprived in some way, then depression may result, depending on how they deal with it.

(In a recent study by the Queen Elizabeth Medical Centre in Western Australia, of 400 children aged 9 to 12, 16 were found to be clinically depressed, with 112 assessed as being vulnerable to future depression. Depressed children believed that happiness is achieved through the acquisition of fame, money and beauty. Happier children tended to believe that feeling good comes from healthy attitudes and pursuing worthwhile goals.)

Teen depression, or bad moods?

Depression in adolescents may be difficult to spot because sulkiness, irritability, antisocial behaviour, negativity and withdrawal often go hand in hand with growing up.

In younger children, depression may present as morbid preoccupation with death and dying. The child may exhibit extreme fear of being separated from a parent or parents and lose interest in participating in games with other children.

As you progress through the Learning Path, you will come to understand clinical depression in a way that allows you to see how children and teens become depressed, just as adults do, and how their depression can be treated in a similar way.

Children and teenagers can been taught specific skills and ways of thinking which can a) help lift depression and b) help prevent relapse. These skills are already being taught in some schools with remarkable results. You will learn more about this as you continue.

Symptoms of teenage depression

As well as showing many of the same symptoms of adult depression, some symptoms of teenage depression are:

- A downward trend in performance at school or college
- Change in personal hygiene and appearance

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- Destructive and/or defiant behavior
- Hallucinations or unusual beliefs
- Appetite or weight has changed considerably (has lost or gained a substantial amount of weight)
- May appear restless, agitated (pacing, wringing hands) or has slowed down (e.g., spends hours staring in front, finds it hard to move)
- Has lost a lot of energy, complains of feeling tired all the time
- Complaints of feeling guilty or worthless ('everything is my fault', 'I am bad')
- Belief that life is not worth living

Checklist for Teen Depression

You may find the following checklist useful if you fear you or your teenager/child is depressed. Remember that these points refer to changes in behavior. If you are concerned about your child, speak to them about it, and take them to see your doctor if you are still worried. You can also complete the rest of the Learning Path to ensure you have a good understanding of depression.

Snapping at people for no apparent reason – irritable	Mentally confused. Finds decisions difficult to make	More conflicts with parents and siblings than usual
Physically or verbally aggressive	Cannot remember commitments – doesn't keep appointments	Changes in eating and sleeping habits
Abandoning favourite hobbies or sports	Has difficulty staying still or conversely, is lethargic	Changes in feeling, thinking and perceiving
Increased passive TV watching	Changes in relationship to family and friends	Expresses inappropriate guilt, feelings of not being good enough, worthlessness, failure
Increased risk-taking; e.g., dangerous driving	Stops going out with friends; shows no interest in group outings	Expresses hopelessness and having nothing to look forward to
Misuse of drugs and alcohol	Increase or decrease in sexual activity	Speaks in a monotonous or monosyllabic manner
Changes in school behaviors (including training courses and work settings)	May start associating with a different peer group	Has a preoccupation with self; is withdrawn
Frequent absences from school, poorer grades than formerly	Expresses negativity about family	Cries easily, looks sad, feels alone or isolated
Complains of being bored	Loses interest in activities which once were fun	Has fears about having to be perfect
Becomes disruptive in class	Incidents of self-injury. Ideas of killing self	Fearful of doing something bad
Finds it harder to stay on task. Loses concentration easily		

Of course, many of these behaviors are carried out periodically by perfectly normal teenagers, and must be assessed in context with their normal behavior.

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Causes of teenage and childhood depression

In addition to those found in adult depression, causes of teen and childhood depression, or apparent triggers, include additional and often unique situations.

- Social rejection
- Family turmoil
- Failing exams

While the triggers or causes of teenage depression may not appear such major events to many adults, it is the sufferer's perception that is so important.

How important these triggers are to the sufferer is all too evident in the statistics below.

Teenage depression and suicide

- Suicide amongst teenagers & young adults has increase 3 fold since 1970. **(2)**
- 90% of suicide amongst teenagers had a diagnosable mental illness, depression being the most common.
- In 1996 suicide was the 4th biggest killer of 10 to 14 year olds, and the 3rd biggest killer of 15 to 24 year olds.

It is clear that not only are young people becoming more depressed, they are responding to this depression by killing themselves. The high rate of suicide may be due to the intense pressures felt by teenagers, coupled with a lack of life experiences that tell them that situations, however bad, tend to get better with time. They are also less likely to possess more subtle thinking styles, being prone to the more extreme, 'all or nothing' style of thinking. As we will see, this can be a major factor in depression.

People usually kill themselves to escape what they see to be an intolerable and otherwise inescapable situation, not necessarily because they want to die.

Medication for teenage depression – Does it really work?

KEY UNDERSTANDING

- 6 million prescriptions for antidepressants are written for children each year.
- In research, the average age of a depression sufferer studied is 41.
- How relevant are research findings to your average child or teenager?

There is no definitive proof that depression medication is an effective treatment for teenage or childhood depression.

In addition, antidepressants should not be given to children **(3)** as the brain's frontal lobes continue to develop until the age of 20. **(4)**

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Despite the staggering amount of antidepressants prescribed to teenagers, very little research has been done into their effectiveness. From what research has been done, there is no definitive proof that depression medication is an effective treatment for teenage depression.

There are differences in the chemical changes seen in teenage depression sufferers when compared to adults. It is this chemical imbalance that is treated by antidepressants. So, different chemical changes are treated with the same drugs.

In fact there are differences in how teenage and adult brains actually function – the frontal lobe, for example, is still forming up until the age of 20.

Now, we move onto some major facts about depression that may well surprise you...

Notes

1 – Lane, R. E. (2000) *The Loss of Happiness in Market Democracies*. Yale University Press.

2 – UNICEF (1993) *The Progress of Nations*. United Nations, 45.

3 – I Tyrrell & J Griffin (2003), *Human Givens*. Human Givens Publishing.

4 – Robertson, I. (1999) *Mind Sculpture*. Bantam Press.

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Major depression facts

Understanding clinical (major) depression today

MAJOR depression is a huge problem and it is growing. By looking at the statistics we can clear up common misconceptions and make it easier to tackle major depression at its root.

Major depression is the No.1 psychological disorder in the western world. **(1)** It is growing in all age groups, in virtually every community, and the growth is seen most in the young, especially teens. At the rate of increase, it will be the second most disabling condition in the world by 2020, behind heart disease.

The escalation in the problem, as well as the facts relating to recurring episodes of depression show that while the first line treatment of depression by antidepressants may sometimes control the symptoms, it usually does little to give sufferers depression-free lives.

More than ever, we need to look at alternatives to drugs that will equip us to deal effectively with the triggers that allow depression to take hold again and again. This is where drug treatments fail.

Facts on major depression

First and foremost, clinical or major depression is growing at an incredible rate.

- People of all ages, backgrounds, lifestyles, and nationalities suffer from major depression, with a few exceptions.
- Up to 20% of people experience symptoms of depression.
- 10 times more people suffer from major depression now than in 1945 **(2)**
- The average age of first onset of major depression is 25-29

A few key areas of society remain where major depression is not seen. Also, the huge increase in cases of major depression show that it can't be a disease.

KEY UNDERSTANDING

There is 10 times more major depression in people born after 1945 than in those born before. This clearly shows that the root cause of most depression is not a chemical imbalance.

Human genes do not change that fast.

Yet, it is estimated 35 to 40 million Americans living today will suffer from major depression at some time during their lives, with about half of this amount suffering from recurring depression symptoms. **(3)**

This isn't due to more people telling their doctor. In fact, a major issue when considering the effect of major depression on society as a whole is the amount of misdiagnosis, or cases where major depression goes undiagnosed.

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Major depression and suicide

- About a quarter of suicides in the US are felt to be due to undiagnosed, or misdiagnosed major depression.
- Up to 80% of suicide deaths are in sufferers of major depression.

Given that suicide is the 8th largest cause of death in the US, it's no wonder that major depression is classed as "the nation's leading mental health problem"

Even these horrific numbers may not reveal the true picture, given that many suicides will be disguised as accidental death.

Why the sudden increase?

Societies that breed depression, and societies that don't

It is a fact that we all have basic emotional needs that must be met for us to thrive and enjoy life. After the primary human needs for food, water and shelter come commonly shared emotional and physical needs. Without exception we find depressed people are not getting these needs met.

Traditional communities naturally meet many 'basic needs' for emotional support. In the traditional Amish society in the US major depression is almost unknown, as it is in the equally traditional Kaluli tribe of New Guinea (4). In these societies individual concerns are group concerns and vise-versa. You know that if you have a problem other people will help you and you are expected to help out when others need support. We know we are meant to do these things but it's not a 'built in feature' of modern society in the same way.

These days we are much more 'self-focused'. The idea of considering the wider community to be more important than the self is almost impossible to understand for most people.

Major depression is 4th most disabling condition in the world, and 2nd most in the developed world.

As well as the human cost, the burden on society is incredible. Much of the research on this site about effective treatments for depression has been controlled by the US government, in order to try and find the best way to overcome depression. The cost to society is real, and we need to find the best way at beating depression for good.

Notes

1 – Seligman, M. E. P. (1990) *Learned Optimism*.

2 – Seligman, M. E. P. In J. Buie (1988) 'Me' decades generate depression: individualism erodes commitment to others. *APA Monitor*, 19, 18. "People born after 1945 were ten times more likely to suffer from depression than people born 50 years earlier."

3 – Weissman MM, Klerman GL. Epidemiology of mental disorders. Emerging trends in the United States. *Arch Gen Psychiatr*. 1978;35:705.

4 – The changing rate of major depression. Cross-national comparisons. Cross – National Collaborative Group. JAMA 1992;268:3098 – 3105.

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Depression information summary

BELOW are the main topics we have covered in Depression Information, Section 1 of the Depression Learning Path.

If you are not sure about any of them, you can check back now before progressing to Section 2, Understanding Depression.

- How a diagnosis of clinical depression is made
- The symptoms of clinical depression
- Some online depression tests
- The truth about the causes of depression
- The fact that the root cause of over 90% of depression is not a chemical imbalance
- The link between stress and depression
- Depression and genes
- The fact that the rate of depression is growing most quickly in children and teens
- How to spot if your child or teenager is depressed
- The incredible increase in major depression, and the reasons why.

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Understanding depression

THE first step towards overcoming depression is understanding it. What it is, how it works, and what it does to us.

Until now, it has been difficult to link the psychological elements of clinical depression to the physical symptoms.

Now, however, a new breakthrough has profoundly changed our ideas of what depression actually is.

And this breakthrough makes depression much, much easier to treat.

It shows us exactly what we have to do to halt depression in its tracks. And precisely what will stop it coming back.

It removes all uncertainty, and most of the fear from depression.

If you suffer from, or treat depression, **this is the most important section** of the whole Depression Learning Path.

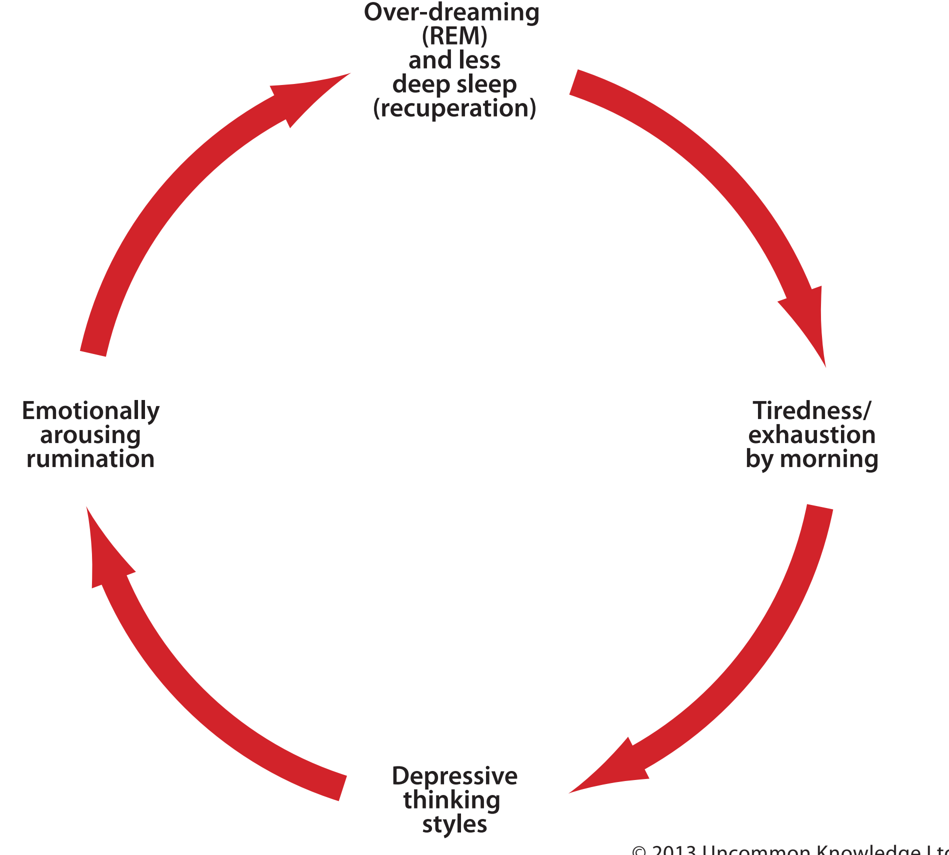
Depression, dreaming and exhaustion: the new link

How your thoughts affect you physically

> "Depressed people dream up to three times as much as non-depressed people.".

This is a startling, and illuminating fact. And when combined with a recent breakthrough in dream and depression research by Joseph Griffin of the Human Givens Institute, it gives us a clear understanding of the how depression affects us physically.

The cycle of depression



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What dreams do

If you are, or have been depressed, you may have noticed that you ruminate, or worry a lot during those periods. Typically, these ruminations are emotionally arousing as they are carried out using 'All or Nothing thinking' (more on this later in the section) and a negative bias. That is, you have a thought and you feel unpleasant after it – anxious, angry or helpless.

The trouble with this sort of emotional arousal is that it doesn't do anything. The thought creates the emotional reaction (usually anxiety or anger) and that's it.

What this does is leave an uncompleted 'loop' in the brain's limbic (emotional) system. Normally, the emotion would be 'played through' by action being taken. For example: You think "That's a tiger in the bushes", feel anxious, then run away. The cycle has been completed. Or, someone annoys you, you shout at them, and the cycle is completed.

(By the way, we are not advocating the 'playing out' of anger as a therapeutic technique. All that does is makes people more angry!)

But what happens when the cycle doesn't complete?

When these emotionally arousing introspections remain incomplete at the onset of sleep then the brain needs to 'do something' with the emotional 'loops' that have been started.

What it does is create scenarios that allow those loops to complete. We call them dreams. The dream acts out, in metaphor, a situation that will allow the emotional loop to be completed and therefore 'flushed' from the brain. In other words, an imaginary experience whose pattern resembles the 'real lifel' one enough to create the same emotional reaction.

Normally, this does its job, and everything stays in balance.

KEY UNDERSTANDING

Dreams and depression

When unfulfilled emotional arousal remains in the brain's limbic system at sleep onset, the brain creates scenarios that allow those loops to complete.We call them dreams.

The dream acts out, in metaphor, a situation that will allow the emotional loop to be completed and therefore 'flushed' from the brain.

In other words, an imaginary experience whose pattern resembles the 'real life' one closely enough to create the same emotional reaction.

For example, during the day you worry about what someone has said to you, thinking that they were perhaps criticising or making fun of you. That night you have an anxiety dream where someone stabs at you with daggers and you try to run away. The dream allows your system to complete the loop started by the emotional arousal.

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However, because you do so much more ruminating, or introspecting, when depressed, the brain has to increase the amount of dreaming you do. And before long you are:

1. Spending too much time in dream sleep (Rapid Eye Movement – REM) and missing out on physically-rejuvenating Slow Wave Sleep.
2. Depleting your hormonal system with extended night-time emotional arousal.
3. Exhausting your 'orientation response' – a crucial brain activity that allows you to change your focus of attention and so motivate yourself. It is also a key part of concentration.

Recurring dreams

If you are continuously having the same problems or ruminating in the same way then you may experience recurring dreams (the same dream over and over). This usually continues until the situation changes or you begin to deal with it in a less negatively arousing way.

Why are my dreams so weird?

Dreams exaggerate the feelings they represent from waking life, so even if you have just had a fleeting moment of anger at someone during the day, the dream that flushes this out may involve you becoming furious.

As an aside, dreams usually just 'borrow' imagery from the your surroundings.

So, for example, images from a recent T.V program may be used by the dream when representing something from real life. So the fact that you kill your brother in a dream, for example, doesn't necessarily mean you have any problems with your brother at all!

Depressive thinking styles mean more arousal

Depressive thinking styles will tend to cause more negative emotional arousal, and therefore more dreaming. This extra dreaming is to try to 'clear the brain' for the next day, but because our negative arousals are excessive when depressed, our natural rhythms find it hard to cope with this "over-dreaming":

Why is over-dreaming bad for me?

Basically, because dreaming is hard work.

Dreaming itself is not a restful activity. Dreaming is called 'paradoxical sleep' because brain wave patterns are similar to those of the brain when completely awake.

Dreaming is a state of arousal.

As far as much of your brain is concerned, your dream is real. So adrenaline and other stress hormones in your system will be active in the body.

This is a double edged sword, because over-dreaming, as well as using up these hormones and energy, is actually making it harder for the body to make more. As you try to flush out the incomplete emotions, you spend more time in REM sleep, and therefore less time in deep sleep, when your body should be recuperating in preparation for producing these hormones for the next day.

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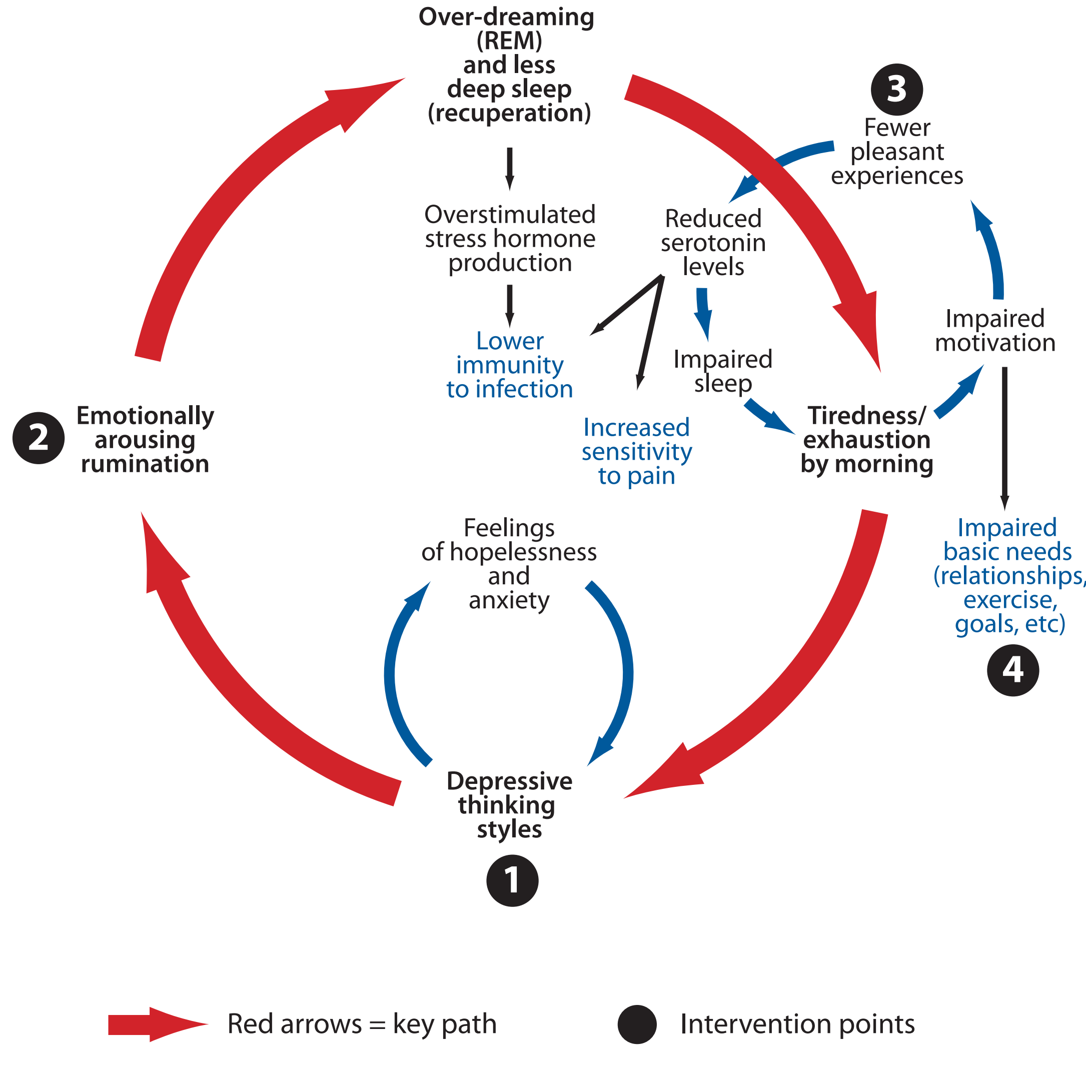
So if you are over-dreaming you're not resting but flooding your system with adrenaline and other stress hormones. If most of your sleep consists of dreams, your body and mind will begin to feel very tired during the day. Depressed people often report that the worst time of day is first thing in the morning.

Sometimes a depressed person may start waking up early in the morning and not be able to get back to sleep. This may be a way of the body trying to cut down on over-dreaming in order to try and lift depression.

This depletion is also why depressed people often feel at their worst first thing in the morning. As the day progresses, their hormones replenish themselves and their energy levels increase, and they are better able to motivate themselves.

Here's a more complete picture of how depression works:



(Note: Levels of the stress hormone cortisol are much higher in depressed people. **(1)**)

And because we can clearly see that what maintains the clinical symptoms of depression is emotionally arousing introspection, or rumination, we know exactly how to deal with it. Cut down the amount of emotional arousal.

More on the cycle of depression next…

1 – Nemeroff, C. B. (1998) The neurobiology of depression. *Scientific American*, 278, 6, 28–35.

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Using the cycle of depression

DEPRESSION affects not only how we think, but also our immune system, our sleep patterns and the natural processes the body and mind use to stay in good physical and mental order.

The cycle of depression explains all the symptoms and signs of depression, and gives us an effective strategy for overcoming depression.

To beat depression for good, we have to break the cycle in as many places as possible, and stop it from re-forming.

As depression progresses, we get locked into a trance-like state – as we become emotionally aroused with negative emotions, our brain treats this arousal as a traditional 'threat' and reverts more to ' All or Nothing thinking' reducing our possible outcomes even further.

- The more emotionally-arousing, negative thinking we do, the more we dream.
- As the excessive dreaming causes more REM sleep, meaning less deep sleep, we become exhausted.
- The more exhausted we are the more we are likely to interpret reality in depressing ways.
- The cycle continues by finally affecting our immune systems, and periods of repair and re-growth we undergo in deep sleep, affecting our health, which can only add to depression.

So it's clear to see what are commonly given as causes of depression, may well be triggers, but fail to give us the complete picture. Only when we understand the connection between depressive thinking styles, emotional arousal, dreaming and exhaustion does the true essence of depression become clear.

From this understanding we can clearly understand the physical effects of depression, why they happen and how to prevent them…

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The physical effects of depression

ONE of the main reasons depression is often considered a disease is because of the all-too-real physical effects of depression suffered by depressed people.

These physical signs help us to complete the loop, or cycle of depression that puzzles both sufferers and those closest to them as to why it's so hard to break the cycle or "snap out of it".

How we deal with the emotional arousal caused by depressive thinking is what ends up making us more exhausted, and therefore less able to cope – the over-dreaming we talked about in the last part of the Depression Learning Path.)

What is significant in the physical signs of depression amongst sufferers is

- The overwhelming amount of sufferers that are chronically fatigued.
- The increase of physical aches and pains that have no apparent source.
- Depression sufferers' increased susceptibility to disease.

Being depressed can feel like a physical disorder because it is so exhausting, and because it can actually hurt.

Depression is bad for you

During deep sleep, our bodies immune system is under repair. Lack of deep sleep is common amongst depression sufferers due to the excessive time spent in REM. Without this time to repair, our immune system is weakened, making us more susceptible to disease.

In addition, a sustained increase in stress hormones actually suppresses the immune system.

Depression, serotonin and pain

Depression and the neurochemical serotonin are now strongly linked in most peoples' minds, especially since the advent of SSRIs – the most famous being Prozac – which are widely thought to work by blocking the re-uptake of serotonin from the releasing neuron.

(The big mistake here is assuming that lack of serotonin causes depression, and therefore drugs are the long-term answer. It's like saying that you need drugs because you are hungry, rather than just eating.)

If an episode of depression causes a change in your serotonin level, this can have an effect on your pain threshold too. Because serotonin helps keep 'pain gates' closed, a lack of it can make you feel more pain. (Back pain is very common amongst depression sufferers).

Serotonin also helps modulate sleep, which is another explanation for the sleep disturbance encountered by those with depression.

So this also explains why people can get such immediate relief from drugs – serotonin is so strongly involved in sleep regulation, pain perception and mood that an increase can have a huge effect. The danger of course, is becoming dependent on drugs instead of tackling the root cause of the depression.

And also, all anti-depressants work by suppressing REM sleep, which as you now know, will lift depression. Again, however, this is treating a symptom, not the cause.

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The cause is the emotional introspection done by depressed people, and the key place to start reducing that is with your thinking styles…

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Thinking styles and depression

AS we saw earlier in the Depression Learning Path, depression:

- Is not an inevitable consequence of unpleasant events
- Cannot be explained as a disease
- Is not caused by hormones, or brain chemicals

Although one or more of these may figure in depression, depression is much more than any one of them alone. In this section, we are going to look at the psychological component of depression – the way you think, and how the study of this has led to some of the most effective treatment for depression.

Shared thinking styles for depression

Depressed people everywhere think in remarkably similar ways. Understanding what these thinking styles are and why they form a pattern, is a major key to beating depression for good. (1)

Depression, to be ongoing, has to be maintained. Otherwise, depression will simply evaporate over time. This maintenance is performed by thinking styles that encourage any introspection to be emotionally arousing.

What's the difference between depression and prolonged sadness? (Not a chemical imbalance!)

It's natural to feel sad for a while when something sad happens. When this happens, we may find our energy levels drop and we become more insular to allow us to adjust to our changed life. This is what grief is for.

The chemical imbalance often cited as the cause of depression is just as often present in someone who is grieving.

The key differences between grieving and depression can be said to be:

- The person not suffering from depression can "see beyond" the sadness. Even if they haven't formed the thought, unconsciously they know that the sadness will lift. Depression often makes the sufferer think that 'things will always be this way'.
- The sadness, or depression, will only affect specific things, even if it is "always there" for some time. Although the mood may be constant, it doesn't "color" everything.

So it's the event itself that is sad, not life in general. And even if this thought or feeling arises, it is only temporary.

Depressive thinking leads to depression leads to depressive thinking leads to…

As we explain these thinking styles you will see how each helps to maintain depression, by altering how we perceive reality.

It's these thinking styles that make it so hard to see an end to the depression, as they limit our possibilities of thought. Once these patterns take hold, the emotional arousal they cause begins to affect us physically.

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If you are thinking now "Yeah, but you don't know *my* life!" – remember this:

KEY UNDERSTANDING

There is nothing so awful that you can imagine that someone, somewhere, hasn't survived without becoming depressed.

It is not your fault if you are depressed, but there are concrete, effective things you can do about it.

One of the things depression needs to survive, is a "negative spin"…

Notes

1 – Peterson, C. and Seligman, M. E. P. (1984) Causal explanations as a factor for depression: theory and evidence. *Psychological Review*, 91, 341–74.

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Negative 'spin'

> "Nothing is good or bad but thinking makes it so."
> William Shakespeare

To understand clinical depression, it is essential to understand that people don't reflect reality (events, other peoples' comments etc.) so much as interpret it.

The same event can have completely different meanings to different people, even if their circumstances are the same.

Depression is partly maintained by how we interpret reality. The 'spin' we put on things. Knowledge about how this happens can turn lives around.

Remember from the cycle of depression that too many negative, emotionally arousing introspections lead to over-dreaming, which leads to exhaustion and depression.

So, to recap, events don't have any intrinsic 'meaning' until human beings add it.

KEY UNDERSTANDING

Say a tree falls over in the forest, and no-one is there. It has no meaning whatsoever. Then along comes a walker, looks at the tree and thinks, "What a shame, such a beautiful old tree blown down in a moment."

(Meaning=sad!)

At the same time a nearby householder looks out of his window and thinks, "What a piece of luck! That tree has blown down and the view is absolutely fantastic now."

A local beetle considers it great luck because he and his family now have somewhere to live for the next 29 generations!

(Meaning=happy!)

In psychotherapy, countless pieces of research have shown that changing the meaning of something for someone is the most effective intervention you can make. Called 'reframing', this technique puts a new frame of reference round an event.

This shows that the meaning you attach to things is extremely important in determining how you feel.

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Depression can turn good things into bad by applying a meaning that harms us. For example, if I phone someone and leave a message and they don't get back to me I can tell myself this may be because:

1. 'Maybe they are away'
2. 'Perhaps they haven't picked up their messages'
3. 'Their machine isn't working or they phoned back when I was out'
4. Or: 'They didn't phone back because they don't want to talk to me because they don't like me!'

Any of these reasons could be true, but depression will tend to make you choose 4, or a similarly depressing explanation.

> "People who tend towards analysing what has gone wrong in their lives, reviewing the past selectively (picking out the negative aspects), catastrophising every little setback, dreaming up future disasters or engaging in self-blame, tend to stay locked into the state of depression instead of rising above it. This explains something observed for some time – that depressed people habitually adopt a particular way of thinking to explain things that happen to and around them."
>
> Chap 10, *Human Givens*, Tyrrell & Griffin

How to depress yourself

An extremely useful way of looking at thinking is called the 'explanatory styles' model (sometimes called attributional styles.) This is how it works…

EXPLANATION	WHAT IT MEANS
Internal or **External** *'Me' or 'Not me'*	**Internal** "It's my fault or responsibility" **External** "It's someone else's fault, bad luck, or whatever."
Global or **Specific** *'Everything' or 'Just this'*	**Global** "My whole life is ruined!" **Specific** "That will be bad for that part of my life.
Stable or **Unstable** *'Forever' or 'Just for now'*	**Stable** "This will last forever." **Unstable** "Things will change over time"

Now, these explanatory styles do not just apply to the way you look at bad events, they are just as valid for good ones.

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A depressive style for

- **bad** events is **Internal**, **Global** and **Stable**,
- and for **good** events is **External**, **Specific** and **Unstable**.

So imagine you have two events happen in your life, one good and one bad.

For example: Good event – you get a new job. Bad event: your teenager gets bad grades in a set of exams.

Now, if you applied the most depressive style of thinking to these two events, you would get something like this:

Bad event	Depressive style	Outcome thought
Teenager gets poor exam results	**Internal**	"I'm such a lousy mother. He's obviously feeling neglected at home and is trying to draw attention to himself."
	Global	"His life is ruined, he'll end up on the scrap heap without good grades."
	Stable	"He won't get into college now. When his finals come up and he does just as badly again it'll be a disaster. He's doomed to being one of life's failures."
Good event		
You get a new job	**External**	"I was just lucky. They must be desperate, and mine was the only application."
	Specific	"I might have a new job, but I still haven't got any friends."
	Unstable	"They'll sack me as soon as they discover what a mistake they've made."

Making the most of the bad and the least of the good

Take a look at the above and you'll see how you can easily:

Good Event:

- Write off your successes
- Fail to get any emotional satisfaction
- Miss out on a boost to your self esteem
- Fail to get a realistic idea of your abilities

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Bad Event:

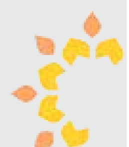
- Blow things out of proportion
- Dramatically increase the negative emotional impact
- Fail to see possibilities for change
- Take responsibility for things outside of your control

And when you are depressed, because of your state of emotional arousal and/or exhaustion, you are more prone to 'allocate' meaning to something incredibly quickly, which is why tolerating uncertainty is such a key skill…

Tolerating uncertainty: first impressions last

Uncertainty is an unpleasant thing. Human beings dislike it intensely, and when depressed or anxious, it troubles them even more. In fact, a good equation for anxiety is

Anxiety = Uncertainty X Importance



Depressed people often doubt themselves in all kinds of ways, but seldom in their judgment about their own interpretations of things.

A common trait displayed by those suffering from clinical depression is not being able to tolerate uncertainty – having to assign a meaning quickly to everything that happens. The depression will take care of "filling in the gaps" in an explanation of events.

High levels of emotional arousal will tend to make you assign meaning to things very quickly, as these levels of arousal are usually reserved for life-threatening situations.

Relax a little

Tolerating uncertainty is a prime emotional skill. Established negative thinking patterns can mean that we lose this skill. One way to break out of the arousal-meaning loop is to relax your body and mind, and do it on a regular basis, at least while first dealing with depression.

But the vital point here is that tolerating uncertainty is a skill, and as such, can be learned.

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KEY UNDERSTANDING

Learning how to tolerate uncertainty – generating multiple explanations

When children are taught in schools about generating multiple possible meanings for why things happened (some of which don't reflect badly on them) then they are less likely to depress as adults.

They literally become more flexible in their thinking. This early teaching of emotional skills has been termed 'inoculation for depression'.

The more possible explanations you can generate, and the more effort you put into doing that, the harder it will be to assign an immediate and definite meaning to an event, and the less likely you are to experience a negative emotional reaction.

Depression literally distorts our perception so that 'good becomes bad and bad becomes disaster.' It's clear that if we only have limited interpretations for why things happen, then change can seem difficult.

Depression acts like a vicious circle because the more depressed we feel the more likely we are to frame events/ourselves/others in a negative light. The more we frame things negatively the more depressed we will feel.

However, this doesn't mean that the answer is 'positive thinking'! We need to look at ways at being more realistic, while at the same time breaking the vicious circle…

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Depression and control

BEFORE we move on to how to break the cycle of depression, we're going to go a little deeper into how your sense of control affects depression, which we touched upon in the last stage of the Depression Learning Path.

It is common for depressed people to feel helpless, with little control over things. Or, alternatively, to feel that everything relies on them.

This extreme perception of control, either too much or too little, helps maintain depression in the following way.

- Too little control – the person stops doing things that could improve their situation, perhaps ceasing activities they used to enjoy.
- Too much control – person tried to control things they can't and may become angry or anxious when they realize things aren't happening the way they wanted. They may also take responsibility for things outside their control. This adds to the emotional arousal that maintains depression.

'Learned helplessness', or feeling trapped

A common feeling that accompanies depression is that of being trapped in an intolerable situation. The depressed person can often see two alternatives, neither of which is possible, and without change the existing situation is too painful (more on this in 'All or nothing' thinking, next in the Learning Path).

Depression causes this illusion.

All too often, this feeling leads to suicide as the depressed person feels that their situation is insoluble by themselves or others.

In almost every situation, there is (at least one) acceptable alternative. Sadly, depression rarely lets people see it. This is why help from a correctly trained professional can be invaluable. They will be aware of the common thought patterns you may be experiencing, and have experience in helping you break out of them. (We will look at how to choose a therapist or counselor later in the Learning Path.)

A nasty rat experiment

Rats, like people, can be 'trained' to feel and behave helplessly.

In one famous experiment, rats were held down in ice-cold water until they stopped struggling. This taught them, through experience, that effort was futile and that nothing they did made any difference.

Then, 2 groups of rats, the second being a group which had not undergone this experience, were left in cold water without being held.

The group which had previously been held began to drown, on average, much, much sooner than the 2nd group of rats.

Some of the 2nd group, which had not been held immobile, actually managed to escape! Our depressive rats were behaving as if they were still helpless even when they were not.

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This experiment has been repeated in many ways, some on humans.

KEY UNDERSTANDING

Through experience, you can think, feel and behave **as if** you are helpless in a situation, when in fact **you are not**.

The very nature of this often means that you cannot find your own way out, and need outside help to do so.

Learned helplessness in everyday life

So how does this happen in everyday life? Well, perhaps after several bad relationships, you may get the feeling that 'no matter what I do I'll never be in the right relationship'.

Or someone whose parents divorce may develop the feeling that 'I'll always lose any people I become attached to!' Being abused by a partner may lead you to imagine that you have no control in relationships generally.

Learned helplessness is exactly that – learned. Life experiences can cause 'learned helplessness' – by reducing your feeling of control as well as your available options in a situation, it can further add to the depression.

But because it is learned, this means we can learn to challenge it. New skills can break this pattern.

We can then, often with a good therapist, increase our number of total available responses in a given situation, and so increase our feeling of control.

Control: if not on the outside, then on the inside

Remarkably, people can have very little external control but not become depressed because they feel they have some kind of internal control.

Some research done on survivors of imprisonment and torture in South American regimes showed incredible results. It would be fair to say that these people had almost no control over their situation. Yet, in psychological terms, startling differences were found in the effects on the survivors.

The ones who were least traumatized and who had not become depressed during or after their captivity were the ones who had maintained a feeling of control even during torture.

When questioned they reported that they did this, for example, by screaming after counting to ten in their head before doing so. Or that they knew they would give information but would only give it at a certain time of day. They had little outside control but still maintained an internal sense of control.

It is this sense of control, which is so important. We may find ourselves in a situation where we have little control – such as waiting for the result of a medical examination, or waiting to learn whether someone still wants to be our lover. What can we do?

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The only control we have during these situations has to be internal. By exercising control over different aspects, such as how or when we will react, we can retain a sense of control.

We can learn to tolerate uncertainty and 'be cool' without knowing the result of something for a while, in the meantime managing our emotional response.

The illusion of too much control

The other end of the spectrum from 'Learned Helplessness' is taking responsibility for things over which you actually have very little, or no control. Which, as you would imagine, can lead to major problems!

On being a rain god

Take the real-life example of a depressed woman who felt guilty over a picnic that she had organized being ruined by unexpected rain.

The depressed woman somehow blamed herself for the fact that the picnic had been rained out, despite the following facts:

- The forecast had said it would be fine.
- Her friends had still appeared to have fun under a big tent in the park.

All this was filtered out by the depressive thinking styles we looked at in the last part of the Depression Learning Path. She continued to see this event as evidence that she was a 'walking disaster area'.

Depression can make us ignore evidence which 'doesn't fit' with the depressive focus of mind.

All things to all people

Trying to be 'all things to all people' is a non-workable strategy.

Nobody can exert so much control so that everyone likes them. We need to be aware of how much or little control we assume we have over different areas of our lives.

It's less depressive (and more realistic) to realize that in some situations you do have control but only up to a point.

When a depressed person begins to generate alternative reasons for why things happen (or at least alternative possibilities) then the depression begins to lift. Depression requires a narrow, set focus to maintain itself, and these alternative reasons make that diminish.

Now we'll take a look at 'All or Nothing', or 'Black and White' thinking, something that almost all depressed people will recognize…

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All or Nothing thinking

MOST life events are not 'completely disastrous' or 'absolutely wonderful' but contain elements of both good and bad. Depression makes people think in absolutes.

All or Nothing, or 'Black and White' thinking is the thought pattern that allows us to generate a "flight or fight" response to danger. It is still needed in the world today, but not many times a day in relation to non-life-threatening stress, as so often happens with depression.

Because All or Nothing thinking is emotionally arousing, it causes over-dreaming and maintains depression, as described in the page on the Cycle of Depression.

All or Nothing thinking and depression

All or Nothing thinking is found in depressed people all over the World. This is because it is part of the most primitive of human responses: **The Fight or Flight Response**.

When faced with a life-threatening situation, we must make a snap decision and act on it. There is no time for 'maybe this', or 'maybe that'.

Either decision will create an emotional reaction to allow us to fight or flee to the maximum of our ability.

Earlier in the Depression Learning Path, we talked about the importance of tolerating uncertainty when looking to overcome depression. All or Nothing thinking is the opposite of this. In a survival situation, there is no room for uncertainty, we simply have to decide to either run away or fight. Uncertainty causes hesitation, which would increase our chances of being killed.

But these responses evolved for times that were much more physically threatening. These days they are rarely required, at least not to that extent.

Seeing shades of gray

Since All or Nothing thinking is another thinking style strongly linked with depression, learning not to always think in 'all or nothing' terms but to see shades of gray is immensely helpful in tackling depression. It greatly reduces, or stops the emotionally-arousing thoughts that are necessary to maintain the depressed state.

The more we polarize our thinking the more likely we are to become depressed because extreme either/or thinking stimulates the emotions much more. Statements like "I'm a terrible person!" or "She's perfect; she's a saint!" or "I'm just a failure!" oversimplify life and cause massive emotional swings. Few marriages, holidays or jobs were 'complete disasters' but had different elements within them.

From this, you would expect that people prone to depression also get much 'higher' when positively excited. And indeed this is true, research shows that people who suffer from depression often need less stimulation to get really 'up'.

For a healthy emotional life, it's not more extreme happiness we need, but balanced emotions.

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KEY UNDERSTANDING

More Calmness = Less Depression

Research shows clearly that people who experience extreme emotions ('positive as well as 'negative') are much more prone to depression. **(1)**

So, if you are 'addicted' to getting high levels of emotional stimulation from experiences, conversations, relationships and so on, it could be time you started doing with less.

For less depression, it's not more happiness we need, it's more calmness.

Spotting warning words

As an ongoing way of perceiving reality, All or Nothing thinking is emotionally and physically damaging. If you spot yourself using this style, challenge yourself to think differently. There are particular words that people often use when thinking in this way. You can learn to spot them.

Always	Never	Perfect
Impossible	Awful	Terrible
Ruined	Disastrous	Furious

Of course, thinking and talking in an 'All or Nothing' way is much more emotionally exciting, and so may be difficult to give up. However, we all talk like this at times, particularly when excited or angry.

To look at how we can begin to incorporate the "gray", take for example a child failing a math exam.

They could say to themselves: 'I'm just plain stupid!' or they could say: ' I'm bad at math but I'm pretty good at English' (or sport, art, making people laugh or whatever it happens to be). The first statement is Black or White while the second focuses on lots of different elements and is not indicative of depressive thinking.

(Note how this ties in with Explanatory Styles earlier in the Depression Learning Path.)

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We can all make inner statements about ourselves but that doesn't make them true. Consider the following questions:

Can I be basically an intelligent person and still do something stupid?

Can I love my children and still get angry with them sometimes?

Can my partner love me but sometimes be insensitive?

Can one part of my life be difficult and other parts be easier and more enjoyable?

Can a part of my life be difficult now but in the future get easier?

Can some parts of an experience (such as a social engagement or vacation) be awful and other parts of it be OK?

Becoming less rigid in our thinking allows us to avoid using All or Nothing statements to depress ourselves without examining their validity. Using this 'cognitive' technique will literally allow you to spot what you are doing and therefore challenge its accuracy.

Remember: A major reason people depress is because of the way they perceive reality. Once this begins to broaden, depression has little to cling on to and will start to lift. Depression often centers around one recurring belief, such as "I'm just not the sort of person other people like."

Deliberately challenging this and coming up with alternative evidence starts to break down the depression. This can often be easier with the help of a friend or properly-trained therapist.

An important note: trauma (PTSD) and depression

People who suffer from post traumatic stress disorder (PTSD) may find that they become depressed. The symptoms of PTSD are intrusive, terrifying 'flashbacks' to the original tramua, which keep the brain in a high state of emotional arousal.

In this state, it is extremely difficult to think in a balanced way, because as we have already seen, when emotionally aroused, the brain's default mode of thinking is 'all or nothing'. In addition, the thought that life will always be as difficult as it is when experiencing traumatic flashbacks is a depressing one in itself.

Happily, we can now stop flashbacks in a single session using the 'rewind' technique (a version of the neuro-linguistic programming (NLP) 'fast phobia cure). **(2)**

Critical incident debriefing, the most widely available approach to treating trauma often makes the condition worse. **(3,4)**

Often, removal of PTSD in depressed people is enough in itself to lift their depression.

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Notes

1 – Martin, P. (1997) *The Sickening Mind: brain, behaviour, immunity and disease*. HarperCollins.

2 – Guy, K. and Guy, N. (2003) The fast cure for phobia and trauma: evidence that it works. *Human Givens*, 9, 4, 31-35

3 – Wessley, S., Rose, S. and Bisson, J.A. (1999). A systematic review of brief psychological interventions ("debriefing") for the treatment of immediate trauma-related symptoms and the prevention of post-traumatic stress disorder (PTSD).

4 – Tehrani, N. (1998) Debriefing: a safe way to defuse emotion? *The Therapist*, 5, 3, 24-29.

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Understanding depression summary

BELOW are the main topics we have covered in Understanding Depression, Section 2 of the Depression Learning Path. If you are not sure about any of them, you can check back now before progressing to Section 3, Treating Depression .

- The amazing new link between dreaming and depression and how this shows us the way forward
- Depression causes, and is caused by, particular thinking styles
- How we 'add meaning' to things and why this is important for depression
- How the Explanatory Style we use can most of bad events whilst discounting good ones
- The importance of tolerating uncertainty
- Why a realistic sense of control is key
- How and to spot All or Nothing, or Black and White Thinking and why it is dangerous
- The physical symptoms of depression and what causes them
- The cycle of depression. How depression works (diagram).

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Treating depression

Treating clinical depression: What treatments actually work?

SO far in the Learning Path, we have looked at a lot of background on what clinical depression is, how it works, and what the facts are as far as research goes. Now you will see what this knowledge leads us to know about depression treatment.

- What are the drug treatments for depression and just how effective are they?
- How effective are alternative approaches, such as therapy, at treating depression?

How to best treat depression?

Recent depression research shows that how we perceive our depression, what we actually think it is, is actually important in the efficacy (efficiency) of the treatment we undergo. What this means is that knowing all the facts about depression, really understanding depression, is incredibly important.

So if you have completed the Depression Learning Path this far, you will be well placed to make the most of whatever treatment you choose.

Research into treating depression

So much research has been done on depression, the right information is out there. However with so many vested interests, as well as different fields of study, it's hard to get a clear picture of what is actually the most effective way overall to beat depression for good.

Much of what you read here is based on a massive meta-study controlled by the US government, incorporated the findings of over 100,000 individual pieces of research. The research was carried out over a fifteen year period. (1)

The research compared the use of depression medication against various types of therapy. It also looked at how effective each treatment was at preventing further episodes of depression.

By comparing this volume of depression research on a "like for like" basis, we get a pretty clear picture of the most effective way of treating depression.

Treating depression with drugs

It's possible that, like millions of others, you may be taking drugs (antidepressants) of some kind to treat depression. Antidepressants are often the first treatment option prescribed by health professionals.

By understanding that antidepressants actually treat what is a common symptom of depression, rather then the condition itself, we can begin to understand some key facts about antidepressants, namely:

- Why antidepressants are only effective in around one third of cases, and partially effective in another third. The other third of cases get no benefit at all.
- Why the rate of relapse is so high when depression is treated with antidepressants alone?
- For many people, the side effects are more unpleasant than the depression itself, so they discontinue treatment.

We'll also consider why, if these drugs are as good at beating depression as we are told, is depression on the increase, and sufferers treated solely with antidepressants have an 80% chance of having a second episode of major depression?

If depression is making you feel really bad, the relief that antidepressants can sometimes bring can be very welcome. However, if you want to have the best chance of avoiding a relapse further down the line, it is essential you get the right kind of therapy, or skills training. We'll look at this later in the Depression Learning Path.

The cart before the horse

One of the main reasons given for depression being described as an illness (and therefore to be treated with drugs) seems, at the least paradoxical, if not misleading.

It is reasoned by some that the high rate of relapse after drug treatment indicates that depression should be treated as a chronic disease, i.e. treatment by long term, high dosage medication.

This is the explanation used, rather than the fact that **drugs do not treat depression, merely the symptoms**.

Yet, if we consider:

- The average length of depression, if left untreated is 8 months.
- Depression medication, typically, has to be taken for 6 weeks before it is known if it is effective or not, and then continued for 6 months.
- Citing relapse as a reason, some treatments recommend a "3 phase approach' which can last well over 2 years.
- Other treatments, such as a combination of cognitive, behavioural and interpersonal therapy, have a much lower rate of relapse. (We recommend that relaxation techniques are also used, to calm the emotions and allow a faster, more effective participation in therapy. It is also essential that the patient's lifestyle is checked to ensure that their basic emotional needs are being met.)
- Also, we should take into account the side effects of drug treatments, which we will come to soon.

Then it is clear that the ever-growing use of antidepressants as the primary weapon against depression, is highly questionable, particularly as a long-term solution.

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KEY UNDERSTANDING

The 'chemical imbalance' treated by antidepressants is almost always a result of depression, not a cause.

Antidepressant medication can be useful for some people in lifting severe depression symptoms quickly, but should not be the sole treatment for depression.

Without appropriate skills training, therapy, or whatever you want to call it, there is no reason why the depression shouldn't come back when a similar life situation arises again.

Treating depression with psychotherapy or counseling

All psychotherapies are not the same, and some can worsen depression, rather than improve it.

When discussing using the treatment of depression with psychotherapy, it is important to make some distinction in the types of treatment. While some have been shown to have high success rates, others are shown to be less effective than actually leaving the depression untreated.

How does therapy actually work?

Therapy for depression works in many ways – emotional support, problem solving, examining and changing thinking styles, checking basic needs are met, looking at behavior, teaching social and other skills and so on…

However, a good way to think about it is to look at the cycle of depression. Good therapy or counseling will break the cycle as quickly as possible, in as many places as possible and give you skills to ensure it stays that way.

In fact, the quickest way to lift depression is to cut down the amount of negative rumination, or introspection the depressed person is doing.

Now, onto treating depression with drugs…

Notes

1 – Psychotherapy Versus Medication for Depression: Challenging the Conventional Wisdom With Data – David O. Antonuccio and William G. Danton, University of Nevada School of Medicine and Reno Veterans Affairs Medical Center Garland Y. DeNelsky, Cleveland Clinic Foundation. This huge meta-study of over 100,000 pieces of depression research recommends that the first-line treatment for depression should be appropriate psychotherapy, even when the depression is severe.

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Depression medication

> "Despite extensive development, no one type of medication for depression has been shown to be more effective than any other."

THE MAIN difference between types of depression medication, (marketing and cost aside), is in the limitation of side effects. A huge amount of research continues into how drugs affect depression sufferers, and each finding reveals a new twist.

What is obvious is that despite each new development in drugs for depression, depression is still on the increase.

By considering the side effects of medication, the wide range of conditions these drugs are used to treat, and the "hit and miss" success of depression drugs, what is clear is that prescribing medication for depression is far from an exact science.

In fact, most drug companies will freely admit they don't really know how these drugs work in treating depression. For example, recent research show that despite their name SSRIs, Selective Serotonin Reuptake Inhibitors, may actually work by affecting levels of glutamate, not serotonin.

Here we'll look at how antidepressant work, or at least how they were intended to work.

> "Regarding depression as 'just' a chemical imbalance wildly misconstrues the disorder. It is not possible to explain either the disease or its treatment based solely on levels of neurotransmitters."
>
> Yale University neurobiologist Ronald Duman, Ph.D., *Psychology Today*
>
> March, 1999

Given that this is the basis on which all medications for depression work, we can begin to see how developing effective treatments for depression must go beyond medication. Effective treatment must treat the causes of depression, not just the symptoms.

Types of depression medication

Antidepressants were first used in the late 1950s. Now they are divided into three main classes:

- Tricyclic drugs (TCAs). (sold as Amitriptyline, Imipramine)
- Monoamine oxidase inhibitors (MAOIs) There are three types of MAOIs, phenelzine, (Nardil) isocarboxazid and tranylcypromine, (Parnate) and moclobemide.
- Selective serotonin reuptake inhibitors (SSRIs) – were developed in the 1980's and are the most common prescribed today. They are sold under brand names such as Prozac, Paxil, Prozac, Luvox, Zoloft, Celexa.

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Newer "reuptake inhibitors" work on blocking the reuptake of different neurotransmitters (brain chemicals). Serotonin and norepinephrine reuptake inhibitors are becoming popular. (SNRIs)

In general SNRIs cause fewer side effects than TCAs and MAOIs.

Another type is Bupropion (Wellbutrin) – which is a dopamine reuptake blocking compound. It acts on the neurotransmitters dopamine and norepinephrine.

Tricyclic agents are used in the treatment of:

- depression
- panic disorder
- obsessive-compulsive disorder
- post-traumatic stress disorder
- occasional chronic pain. SSRIs are used in the treatment of:
- depression
- panic disorder
- obsessive compulsive disorder
- bulimia nervosa
- social phobia

MAOIs are used for all types of depression. They have also been used when 'atypical' features were present with the depression such as excessive sleeping, over eating and anxiety.

If you are on antidepressants they may have a different brand name but will generally fall under one of the types mentioned above.

The most commonly prescribed drug type for depression is the SSRI, due mainly to their apparent safety in overdose, compared to others.

How effective is depression medication?

Many people find great relief by using antidepressants. They can be very effective in giving a quick response, to relieve suffering in severe cases of depression. But the long-term use of antidepressants is far from the being the answer to depression. Also, as we have seen, if you are depressed, you need to learn the skills necessary to avoid depression in the future, not just treat the symptoms with drugs.

And despite drugs companies trumpeting SSRIs as 'the answer' to depression, newer antidepressants have just the same success rate as older ones.(1)

Although in the UK, drugs companies cannot advertise their brand-name drugs, this is not the case in the US, Australasia and elsewhere.

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The hard facts – depression drugs and relapse

Antidepressants are shown to be effective in controlling depression in around one third of cases with partial success in another third, but are ineffective in the remaining third.

But where drugs as a treatment for depression really fall down is on the prevention of relapse. Other, alternative treatments such as cognitive behavior therapy, have been shown to have 70% better success rate at beating depression for good. In other words, they have been shown to prevent relapse in 70% more cases than drugs.

But this is obvious! Unless, of course, you consider the cause of depression to be a chemical imbalance. Which we know it is not, in the majority of cases. (See earlier in the Depression Learning Path.)

Since almost all depression depends to a major extent on peoples' situations and how they respond to them, why should drugs prevent relapse?

How do antidepressants work?

Since the breakthrough discovery about depression and dreaming, detailed earlier in the Learning Path, we now know that all antidepressant drugs inhibit the amount of REM sleep we get, reducing the amount of dreaming and so exhaustion. Once again, however, this is treating a symptom instead of the cause of the over-dreaming. Once new styles of thinking are learned, and lifestyle changes made, over-dreaming naturally ceases.

This gives a clear indication why relapse is common on antidepressants alone. And what about long term use…?

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Controlling depression with antidepressants

ANTIDEPRESSANTS have been shown to be effective in controlling depression, or at least episodes of depression, but are they a cure for depression?

Looking at how they affect depression, or at least depressive symptoms, is important when considering ways of actually beating rather than just controlling depression in the long term.

> In thousands of research studies, the treatment of depression with antidepressants alone has been found to produce the highest rate of relapse, compared to what are considered effective therapies in the treatment of depression.

Since we now understand how antidepressants work in controlling depression (from the depression medication section of the Depression Learning Path), the reason for this high rate of relapse seems fairly obvious.

Depression medication and relapse

As we've shown, from all tests and diagnoses, depression is shown to be about thinking styles, and the patterns formed by these styles. One of the symptoms that show these patterns have been set up and maintained is the reduced activity of specific neurotransmitters.

It is this reduction in activity that is treated by antidepressants, not the thinking patterns that caused them.

While on the medication, the effects of the depression may well be diminished, or even vanish completely. But what do antidepressants do to prevent relapse?

Here's a short story that might make this even clearer…

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A clarifying metaphor for depression

A ship, sailing in calm waters, is going along nicely with a following wind. The crew, who know they lack some of the more tricky skills of dealing with bad weather, are perfectly happy in such good conditions.

But then a storm blows up. The crew don't know what to do and so sail right into the middle of the storm. Once in it, they lose their way, not knowing how to set a proper bearing and stick to it.

They go round and round within the storm, getting sicker and sicker, and the ship getting more and more battered. They try to do what they know but nothing seems to work, and after a while they become so exhausted they stop trying.

Eventually, the storm dies down and calm returns. After a time, the crew recover, and sail the ship onward, albeit in its slightly worn state.

They realise that if another storm comes along, they are going to be in the same position again, and so decide to put into the nearest port to learn the skills of coping with bad weather.

So the crew above (the depressed person) realise they don't know how (haven't learnt the skills) to take a ship through a storm (a life crisis, or difficult situation.) Once in the storm (the depression), they don't know how to set a proper bearing (get themselves out of depression.)

Once storm abates (life circumstances change), they decide to learn the necessary skills (balanced thinking styles, meeting basic needs etc.)

What the equivalent of them using drugs would be – who knows? Pouring oil on the sea?

So why don't people talk about curing depression, rather than controlling it?

Mainly because much of the debate on depression is fuelled by the drug industry, and it is well known that drugs do not cure depression. They control the symptoms. A true cure for depression is to learn the skills, habits and thought patterns of people who don't get depressed.

Other areas of treatment for depression have been shown to be highly successful, with a much smaller proportion of patients relapsing than with depression medication. Using the analogy above it is easy to see why.

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"Curing depression" with drug treatment

Without repeating what we said earlier, it is unrealistic to expect drugs to be successful in curing depression when all they do is affect the symptoms – namely levels of neurotransmitters and amounts of REM sleep.

If you have completed the Learning Path this far, you will know the causes of these symptoms and will be able to see how the right approach has a much better chance of curing depression by getting to the 'root' of the problem.

Why do so many people have to change medication?

The use of antidepressants as depression medication is based on artificially increasing the amount of neurotransmitters found in the synaptic cleft, the area between two synapses. Neurotransmitters act as communication agents between the synapses.

But the body adapts to this "intrusive" addition to what is a very complex and delicately balanced system and so the medication becomes less effective. This accounts for why so many people on antidepressants often have to increase dosages, change types of medication etc.

It also explains why the effects of suddenly stopping medication can be fairly extreme.

IMPORTANT

If you wish to cease taking antidepressant medication, see your medical practitioner first. Do not stop taking antidepressants without consulting a professional.

If your doctor wants to change your antidepressant medication because you have become more depressed, ask him or her to think again. When your existing medication is ceased, it takes up to 6 weeks for the new medication to kick in. In the meantime, you may find yourself feeling even worse.

While the chemical changes in the brain due to depressive episodes are temporary, (when the depression lifts the chemical activity, if different at all, goes back to normal), the effects of longer term use of antidepressants can be much longer lasting.

Prolonged use of depression medication has been shown to cause permanent physical changes to the brain's receptors, sometimes resulting in serious long term problems. Often associated with multiple medication, seratonergic syndrome is a neurological condition which results in fevers, seizures and heart rhythm disturbances.

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What prevents depression coming back

When talking about curing depression, we are not simply assessing what will get rid of it, we need to look at what will stop it coming back.

As we have seen, depression works through the type of cyclical thinking patterns that work on a "downward" spiral. (See the Cycle of Depression). It fuels our negative bias of events, reducing our apparent options, changing our behavior and affecting our sense of control.

What prevents relapse is the sufferer possessing the ability to skills effectively with life experiences, and perceiving these experiences in non-depressing ways.

This doesn't mean being unrealistic. It means being able to assess situations, our own feelings and our sense of control realistically. This is precisely what effective therapies such as cognitive and behavioral therapy do.

Positive life experiences increase levels of serotonin just as antidepressants do. Negative introspection reduces serotonin levels.

Curing depression is more about the sufferer learning a set of skills that innoculate them against further bouts of depression, rather than a 'magic bullet'.

If you taking, or considering taking antidepressants, you should be aware of the possible side effects…

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Side effects of antidepressants

> "The main reason for people stopping a course of depression medication is the side effects of the antidepressant."

IT IS BECOMING clearer and clearer that antidepressants are far from benign drugs. And unfortunately, the combination of depression and medication, as well as still being very much trial and error, has some unique worries due to the nature of the condition itself.

As with all drugs some people react badly to antidepressants, whilst side effects can seem quite mild in others. The irony here of course is that, helpful as antidepressants may be for some people at some times, these side effects can be very depressing in themselves.

Because no one antidepressant has been proven to be any more effective than any other, the choice of which drug to prescribe often rests on their different side effects!

The overwhelming popularity of SSRIs (selective serotonin reuptake inhibitors) was in part due to their apparent "safety" over more toxic drugs when used improperly. Some of the Tricyclics are extremely toxic in overdose, such as Dothiepin, Amitriptyline and Imiprimine.

However, in addition to other dangers, there is also an established direct link between suicide and violent behaviour and the use of SSRIs. **(1)**

Actually, all the effects, even the desired effects, can be considered a side effect of taking a pill. The reason there are so many side effects with antidepressants, is really due to the lack of full understanding about how antidepressants, and depression, affect the brain.

This can can be very different from case to case. Even the drug companies themselves admit that they don't quite know how the drugs work! **(2)**

Antidepressant treatment is often very much "a sledgehammer to crack a nut", especially in cases of mild to moderate depression. Bombarding an incredibly delicate and well balanced system with external chemicals on a long-term basis is bound to create unpleasant side effects. One of the desired side effects is to change the mood of the person taking the antidepressant.

St John's Wort (hypericum) has been shown to be as effective as antidepressants, and have fewer side effects. **(3,4)**

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General side effects of depression medication

Some of the various side effects from the different antidepressants are:

- Dry mouth
- Urinary retention
- Blurred vision
- Constipation
- Sedation (can interfere with driving or operating machinery)
- Sleep disruption
- Weight gain
- Headache
- Nausea
- Gastrointestinal disturbance/diarrhea
- Abdominal pain
- Inability to achieve an erection
- Inability to achieve an orgasm (men and women)
- Loss of libido
- Agitation
- Anxiety

See below for the side effects of specific antidepressant types.

Uncovering the new truths about SSRIs

One of the reasons that SSRIs (including Paxil, Prozac, Luvox, Zoloft, Celexa) are so widely prescribed by doctors and psychiatrists is because they are safer in overdose. This is obviously a good thing because traditionally the most common form of suicide was to overdose on the very antidepressants which were meant to help relieve the depression.

However, there are two very real dangers with SSRIs: one that has recently been the basis of an historic court battle in the US.

1. SSRIs pose greater risks when taken with other drugs, due to their pharmacokinetic and pharmacodynamic properties. For example, SSRIs can be lethal when taken with MAOIs.

2. While being safer in overdose, SSRIs have actually been proven to increase thoughts of suicide or self harm.

Other side effects of SSRIs

Nausea, diarrhea, headaches. Sexual side effects are also common with SSRIs, such as loss of libido, failure to reach orgasm and erectile problems. Seratonergic syndrome is also a worrying condition associated with the use of SSRIs.

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Side effects of TCAs (tricyclic antidepressants)

Fairly common side effects include dry mouth, blurred vision, drowsiness, dizziness, and tremors sexual problems, blurred vision, dizziness, drowsiness, skin rash, and weight gain or loss.

Side effects of MAOIs (monoamine oxidase inhibitors)

Rare side effects of MAOIs like phenelzine (brand name: Nardil) and tranylcypromine (brand name: Parnate) include liver inflammation, heart attack, stroke, and seizures.

Individuals taking MAOIs may have to be careful about eating certain smoked, fermented, or pickled foods, drinking certain beverages, or taking some medications because they can cause severe high blood pressure in combination with the medication. A range of other, less serious side effects occur including weight gain, constipation, dry mouth, dizziness, headache, drowsiness, insomnia, and sexual side effects (problems with arousal or satisfaction).

SSRIs, and SNRIs tend to have fewer and different side effects, such as nausea, nervousness, insomnia, diarrhea, rash, agitation, or sexual side effects (problems with arousal or satisfaction).

Bupropion generally causes fewer common side effects than TCAs and MAOIs. Its possible side effects include restlessness, insomnia, headache or a worsening of preexisting migraine conditions, tremor, dry mouth, agitation, confusion, rapid heartbeat, dizziness, nausea, constipation, menstrual complaints, and rash.

Bupropion (Wellbutrin) was temporarily removed from the market after its initial release due to the occurrence of seizures in some patients. However, further investigation showed that seizures were primarily associated with high doses (above the current maximum recommended dose of 450 mg/day), a history of seizures or brain trauma, an eating disorder, excessive alcohol use, or taking other drugs that can also increase the risk for seizures. With new warnings and lower recommended doses, the chance of having seizures has been greatly reduced.

So, if you're concerned about the side effects of medication, or would like to know about other ways of controlling and curing depression, take a look at what the research says about alternative treatments for depression…

Notes

1 – Glenmullen, J. (2000) *Prozac Backlash: overcoming the dangers of Prozac, Zoloft, Paxil, and other antidepressants with safe, effective alternatives*. Simon & Schuster.

2 – Dubovsky, S. L. (1997) *Mind-Body Deceptions: the psychosomatics of everyday life*. WW Norton & Co.

3 – Linde, K., Ramirex, G., Mulrow, C. D., Pauls, A., Weidenhammer, W., Melchart, D. (1996) St John's wort for depression: an overview and meta-analysis of randomized clinical trials. *British Medical Journal*, 313, 253–258.

4 – Woelk, H. (2000) Comparison of St John's wort and imipramine for treating depression: randomised controlled trial. *British Medical Journal*, September 2.

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Alternative treatments for depression

WITH antidepressants being the first line treatment for many medical practitioners, having access to unbiased information about **effective alternative treatments** is vitally important. So as well as understanding from the Learning Path how depression works, you can ask the right questions and understand fully how other treatment options vary.

We have listed psychotherapy or counseling (effectively the same thing) under 'alternative' because for much of the medical profession, they are still seen that way. International guidelines for the treatment of depression are well established (1), and the types of therapy that are recommended for depression are those that are brief, concentrate on problem solving, attributional thinking styles , focusing attention away from emotions and helping sufferers get basic needs met by, for example, helping improve relationship skills. (2)

> Although you might expect otherwise, the majority of medical practitioners are relatively uninformed as to which psychotherapies are good for depression, and which make it worse.

So there is now little doubt which types of depression counseling or therapy are the most effective, and which are less effective, or even detrimental. Happily, a lot of research has been done in this area.

Here we'll discuss some of the more famous depression counseling approaches and their relative merits (or demerits!) The most famous type of "therapy" is actually very poor in treating depression, so we'll consider this first.

Less effective types of depression counseling

Probably the most famous type of psychotherapy is **psychodynamic counseling**. Because of its fame (or infamy), particularly from Woody Allen's films, it's vital that we understand why depression counseling is ineffective in treating depression, and is likely to make it worse.

This approach evolved out of the work of Sigmund Freud. One of the main ideas is that most behavior is unconsciously motivated and much of our current behavior comes from repressed childhood conflicts. (An extremely dubious premise). Psychodynamic counseling has performed very poorly as far as its effectiveness (efficacy) is concerned.

People, it is believed, need 'insight', before they can change. This means that you have to understand why they are depressed before you can get better. On the face of it, this seems perfectly reasonable, particularly as it seems to match the natural human response to a problem – to find out why.

However, in depression, this style of thinking will tend to make the depression worse. You don't need to be encouraged to do it by your counselor.

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The problems with this type of counseling for depression are many:

1. The focus is predominantly on the past. Depressed people do this plenty already.
2. One main idea is to discover 'the reason why'. There is rarely any single 'reason why' with depression (or any problem), and even if there were, discovering it does not make the depression go away. (If, that is, there was any way to be sure you had the right 'reason why'!) It's called 'psychological archaeology'.
3. Both 1 and 2 increase rumination. Going back over past hurts causes more emotional arousal and gives you more to worry about not less. You know from the Cycle of Depression why this would worsen matters.
4. The counselor using this type of approach is often trained to give little or no direction to the client. This is counter to treatment guidelines (see introduction above).
5. Also from 4, this type of counseling has no fixed time period, and is usually totally passive.

It is not for us to 'discount' psychodynamic or, a related approach, 'person-centred' counseling totally. But it does not work for depression, and we have seen too many people who have suffered from this approach.

Some therapists have been sued for using these approaches in the US when treating depression. Approaches which mainly focus on the past are contraindicated in the treatment of depression and anxiety conditions.

It is becoming more understood that therapy needs to be about equipping people with skills, not trawling through the past.

Why is the 'insight approach' of depression counseling so unsuccessful?

Consider this:

If you know why you blush, does the blushing stop?

If you know why you have a flying phobia, does it go away?

Of course not. No research has ever shown this sort of insight to be effective in curing emotional problems.

Most people, it seems, know why they have a particular problem – or at least have a good idea – but this conscious understanding rarely seems to stop the unconscious behavior – the feelings.

Interestingly though, real insight into depression, the sort provided by the Depression Learning Path, seems to make a huge difference to people sufffering from depression. When our clients understand that they are simply suffering a normal response to excessive levels of emotional introspection, part of the introspection is dealt with – the awful ongoing thought of "What is happening to me?"

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KEY UNDERSTANDING

"Counseling or therapy for depression should be time-limited, future-oriented, active and focused on learning skills rather than personality change."

So what types of counseling are effective in treating depression?

We'll look now at some effective types of depression counseling and also discuss the core elements in each. This is important as it can help you talk through with your health professional the rationale of any treatment you choose.

So, while the names of therapies may differ, you will know what components depression counseling needs to be effective…

Notes

1 – *Diagnosis*, Vol. 2 Treatment Aspect. United States Public Health Service Agency.

2 – Psychotherapy Versus Medication for Depression: Challenging the Conventional Wisdom With Data – David O. Antonuccio and William G. Danton, University of Nevada School of Medicine and Reno Veterans Affairs Medical Center Garland Y. DeNelsky, Cleveland Clinic Foundation

3 – Dolnick, E. (1998) *Madness on the Couch*. Simon & Schuster.

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Overcoming depression with therapy or counseling

HAVING come this far along the Depression Learning Path, you should understand the difference between simply treating the symptoms of depression with drugs and overcoming depression for good.

Here we're going to look at what research has shown to be the best therapy for overcoming depression permanently. You should already know the types of depression counseling to avoid from the last step.

Many professionals advocate a combination of drug therapy and psychotherapy, but more and more studies show that medication is unnecessary if the sufferer receives the right sort of help. (1)

As well as overcoming depression if you have it now, knowing exactly what depression is means you can recognize the onset of future episodes, if they occur. Gaining new skills, or being able to challenge depressive thinking and behavior at the onset, means you can be confident about leading a depression-free life.

As we have seen along the Depression Learning Path, therapy that is effective in overcoming depression focuses on:

- What we do. (Behavioral therapy)
- How we think about things. (Cognitive therapy)
- How we relate to others. (Interpersonal therapy)
- How things are going to be better in the future. (Solution focused therapy)
- Getting our basic emotional needs met in the wider world
- Helping you find solutions to your immediate problems

and NOT on why you are depressed, or what went wrong in the past.

These types of therapy, far from overcoming depression, will tend to make it worse. (For those of you who have been through the whole Depression Learning Path, this will be repetition we realise. However, it is such an important point, we hope you will bear with us!)

A combination of these above approaches has been shown to work best.

Here's a quick description of the types of therapy found to be effective in beating depression. (Just so we get it straight, therapy and counseling are the same thing, although counseling is more often the non-directive stuff to avoid if you're depressed!)

Behavioral therapy for depression

The basic idea of behavioral theory is that everything amounts to behavior and inner processes are of little or no account. So if people feel miserable it is because of their behavior. Traditional behavioral therapists are less interested in the thoughts and emotions of their patients and more concerned with their behavior as can be observed.

Changing peoples' behavior can have dramatic results but it is now known that people's perceptions and thought processes are also vitally important when overcoming depression.

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Cognitive therapy for depression

Cognitive therapy works on the basic premise that all emotion comes from thoughts. For example: If you think about something scary, you will feel fear.

Basically, the idea behind cognitive therapy is that people learn to 'catch' their thoughts and challenge them so that they can feel differently. Working on your thinking styles is absolutely essential if you suffer from depression. Any therapist or counselor who does not address this with you is going about it the wrong way!

Recent studies of how the brain works have shown that certain emotions occur before thoughts and it is possible to be afraid of something before we can think what it is. However cognitive therapy, if applied skillfully, has done very well in the research for lifting and preventing relapse of depression.

(The danger with cognitive therapy is that it becomes too complex for the patient to understand, so it must be applied with skill, and with consideration for the patient's way of learning.)

Interpersonal therapy for depression

This approach focuses on the way people relate with other people in their lives – how they communicate and express themselves. Whether a person is assertive, aggressive or timid or has 'social skills' is seen as key.

Extremely common in depression sufferers is the lack of satisfaction in various relationships: family, work, social. Depression can cause us to lose access to the skills and the desire to sustain these relationships successfully.

Whether it be feelings of wanting to be alone, not knowing what to say, or just feeling wretched and not wanting to be in company, a large percentage of depression sufferers exhibit what is crudely called "poor social skills" such as:

- Being less assertive
- Being less positive
- Showing negative facial expressions and poor eye contact
- Displaying less interaction in group situations
- Unwittingly carrying out 'off-putting' social behavior such as innapropriate questioning, too much or too little self-disclosure, or missing out small-talk.

Again this therapy can be seen as practical, sensible and very helpful for some people as communication skills are 'teachable'. However like all the other approaches it's not the whole story.

Solution focused therapy for depression

As its name suggests, the emphasis here is on finding solutions to current problems and focusing on future wellness rather than past hurts. This is not to say that the past is ignored but the main emphasis is on teaching new skills and keeping therapy brief and focused. It is an extremely hopeful and motivational form of therapy when applied skilfully.

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Each therapy type contributes greatly to overcoming depression. A good therapist will use all these approaches in a skilful blend.

Notes

1 – Teasdale, J. D. et al. (2000) Prevention of relapse/recurrence in major clinical depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 4, 615–23.

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Getting help with depression

HELP for depression varies wildly in terms of what it considers depression to be, how it treats it and therefore ultimately how effective it is.

The idea that depression can simply be treated as a chemical imbalance is rapidly losing ground. You will know why if you have completed the rest of the Depression Learning Path.

Therefore, the first incredibly important stage of getting help for depression is to **understand what depression is**.

In summary, we'll give here:

- an indication of the best way to get help with depression
- an assessment of depression help in terms of overcoming depression and preventing relapse
- the common features of successful therapies for depression
- what to look for when seeking help for your depression through therapy

Antidepressants as help for depression

As we have seen on the Learning Path, no one type of depression medication has been shown to be significantly more effective than any other. Antidepressants are also very poor at preventing relapse, and more often than not require a long course of treatment.

Self help for depression

Effective therapy needs to incorporate everything that works in lifting depression. You may be able to help yourself effectively, although often it is useful to get the help of a professional.

Here we'll go through what you can do, as well as what you should look for in any therapy you choose to undergo.

What you can do to help yourself

1) Know about your condition – what you know about your depression has been shown to have an effect on well you respond to treatment. Take the Depression Learning Path – it's the best way to start helping yourself.

2) Cut down on rumination. Do whatever you can to decrease the amount of rumination you are doing. (Ruminating is 'chewing over' emotional issues in your mind without coming to any decision to act.)

If possible, decide to put off difficult decisions for 1 or 2 weeks while you get your energy back.

Ways to cut down rumination are to:

- Stop yourself when you spot yourself doing 'all or nothing' thinking. (See thinking styles)

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- Read novels when you have nothing to do, to occupy your mind. (Make them exciting novels, not romance or self help books!)
- Do exercise (see 5)
- Work if you can
- Keep yourself occupied as much as possible in ways that stop you thinking too much!

3) Find ways to assess and monitor your depressive episodes – The way depression makes us adopt all or nothing thinking is a unique and crucial part of understanding depression. The way depression makes us generate seemingly hopeless outcomes to our situation can make it almost impossible to see a way out of it.

Finding ways to gauge your depression can help to show the shades of gray, that will ultimately defeat the black and white thinking on which depression thrives. This is often done in the form of a diary, where you grade how bad your days have been on a scale of 1 to 10, where 1 is the worst and 10 is the best. Then, after 2 weeks or so, you can look back and see how things have varied over that time.

4) Lower your emotional arousal levels. Calming down emotions such as anxiety and anger helps your brain function more subtly and decreases the amount of catastrophising you do. Along with getting proper rest, being able to relax is incredibly important.

Relaxation therapies are effective in overcoming some of the other issues that can co-occur with depression. The effects of panic attacks, anxiety and anger, etc can be lessened and overcome with the ability to relax properly and deeply. Physical disciplines such as Tai Chi, which occupy the mind whilst performing gentle, relaxing exercise can be useful, as can relaxation training such as guided imagery or self hypnosis.

5) Get exercise if you can. If you can increase the amount of physical exercise you get, it can be a great self help for depression. The results of the physical exertion will lift your depression temporarily at least, in addition to the other benefits of exercise. (As always, consult your medical practitioner before starting any strenuous exercise regime.)

6) Do what you enjoy. Do what you used to enjoy doing, even if you don't particularly feel like it. Even complete small tasks within the home if you don't feel like meeting other people. Seemingly mundane tasks, if they have an end result, can result in a feeling of satisfaction, and actually increase your serotonin levels!

7) Maintain a regular sleep pattern. Do not lie in if you feel exhausted in the morning. All that happens is that you dream a large amount if you sleep through the morning, because your REM periods get longer the longer you have been asleep. Set a time to get up every morning, and get up. Try to spend 8-9 hours in bed, and get up regardless.

8) IMPORTANT! Check that you are meeting your basic emotional needs.

More in self help for depression.

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What to look for in a therapist or counselor when getting help with depression

The single, best proven approach for treating depression is a combination of cognitive, behavioral and interpersonal therapy while being brief, solution focused and strategic. If the therapy also includes the understanding of how dreaming figures in depression (which is not yet widely known), it will be even more effective.

(You can always point your therapist towards the Depression Learning Path site. If they are good at what they do, they will be able to incorporate this into their approach quickly.)

IMPORTANT NOTE

Therapeutic **approaches that increase rumination** (going over past hurts and examining what was wrong with past relationships) **worsen depression**.

This includes psychodynamic approaches, gestalt, hypno-analytical and person-centred counseling, plus many others.

The evidence for this is now strong enough to stand up in court. **(1)**

What does this mean? Well, it's therapy that takes place over a short period of time, usually less (and often much less) than 20 sessions, with significant improvement within 6 sessions. It focuses on:

- the way you think about things
- what you do from day to day
- how you relate to other people
- how your current problems can be tackled to lessen the burden on you (practical problem solving)
- it is aimed at making you feel better, rather than changing your personality
- if you suffer post-traumatic symptoms, removing these quickly before other treatment

While the treatments outlined above do have different approaches there are some key similarities. These are the things you should look for in depression therapy, and your therapist or counselor.

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Things to look out for in depression therapy

- The therapeutic, or counseling **approach**
- The treatment has a developed **rationale**, and is **treating key signs** of depression.
- All treatments include some form of **training**: skills that the patient can learn.
- There is a **chance to use and practice these skills**, outside the therapy sessions.
- The treatments have **time limits** and **goals**.
- There is a **follow up plan**.
- Within the treatment, **credit is given to the patient for gaining these new skills**, rather than to the ability of the therapist.

Check that the therapist or counselor

- understands what depression is and how to lift it (compare their understanding with that found in the Depression Learning Path – you can do this on the phone at 'first contact')
- endeavors to make you feel better after every session
- can help immediately with anxiety problems by teaching techniques to lower anxiety, or by deconditioning trauma to decrease flashbacks and general emotional arousal
- is prepared to give advice if needed or asked for (*this may seem obvious, but some therapies deliberately avoid giving direction, and this does not help when treating depression*)
- talks to you in terms you can understand and does not expect you to 'learn their language'
- does not drag you back to talking about the past once anything relevant has been said
- supports you in dealing with difficult emotions, but does not propose that 'getting in touch with your emotions' is necessary for improvement.
- if necessary, can help you develop your social skills so that your needs for affection, friendship, pleasure, intimacy, connection to the wider community and so on can be better fulfilled
- will help you to identify and draw on your own resources, which are often hidden from you by depression

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- considers the effects of therapy or counseling on the people close to you
- knows how to teach you to relax deeply, as this is often a key part of treatment for depression and can result in quick relief from symptoms
- helps you think about your problems in a new and more empowering way, rather than just listening to you talk about them
- may ask you to do tasks between sessions
- will take as few sessions as possible, and will check with you regularly about how you think things are progressing
- will keep track of your progress and report to you regarding it regularly
- aims to increase your self confidence and independence
- is someone you can get on with!

And now, on to the final summary in the Learning Path…

Notes

1 – Dolnick, E. (1998) *Madness on the Couch*. Simon & Schuster.

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Depression treatment summary

Congratulations on completing Treating Depression, and the whole Depression Learning Path!

You should now be fully aware of:

- Exactly how depression works – a better understanding than most medical practitioners, counselors and therapists.
- What to look for in a depression counselor or therapist.
- How to avoid depression counseling that tends to worsen depression.
- What the research says about the best ways to treat depression.
- The side effects of the various antidepressants.
- How depression is diagnosed.
- What the signs and symptoms of depression are.
- What you can do now to help yourself.

We hope you have found this a useful resource in tackling depression. Below is a summary of the final section, but first you might like to know about…

Further resources from Uncommon Knowledge

The Natural Depression Treatment Program – Feel Better, Stay Better

Discover how to use your in-built abilities, skills and needs to escape depression and keep it away with the Uncommon Natural Depression Treatment Program.

This focused practical program is designed to help you feel better from the moment you start. Each section has an accompanying 'Relaxing Review' audio session, where all you have to do is put on your headphones, kickback and soak up 20 minutes of deep relaxation. A depressed brain is a stressed brain, and regular deep relaxation is a foundation for bringing energy, hope and enthusiasm back into your life.

With each and every relaxation session, your brain and body takes a break from the cycle of depression, and in turn, gives you the spare capacity to work through the workbook, at your own pace, and in your own time.

There are no side effects, other than a natural recovery from depression and the harnessing of skills that will help you now and in the future, to protect you from depression.

'How To Lift Depression Fast' Home Study Course (for professionals)

This home study course for professionals working with depressed clients provides a framework for lifting depression in 95% of your clients within 6 sessions.

Treating depression can be depressing in itself, particularly if your client becomes 'stuck' and you begin to worry you're not doing enough for them.

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The Uncommon approach to treating depression is to provide a **deep understanding** of what depression is, and a **solid framework** to help the client take the steps they need to lift depression and discover the skills within themselves to protect themselves for the future.

Section Summary

- What the research says about drug treatments for depression
- Why drugs treat the symptoms of depression, rather than the 'causes'
- The differences between different types of depression medication
- How antidepressants work
- Whether controlling depression with drugs is a good idea in the long term
- The side effects of antidepressants
- Alternative treatments for depression – depression counseling and therapy
- What types of therapy and counseling to avoid
- The best therapy and counseling approaches for overcoming depression
- Self help for depression
- How to choose a good depression counselor or therapist

If you have any comments, please send us a message.

If you have found the site or ebook useful or have any suggestions, we'd love to know!

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The Dreamcatcher

Article originally published in the New Scientist, Apr 12 2003.
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Interview with Joe Griffin – The dreamcatcher

How can you deal with serious depression in just a day?

The important thing is to know how depression is manufactured in the brain. Once you understand that, you can correct the maladaptive cycle incredibly fast. For 40 years it's been known that depressed people have excessive REM sleep. They dream far more than healthy people. What we realised – and proved –is that the negative introspection, or ruminations, that depressed people engage in actually causes the excessive dreaming. So depression is being generated on a 24-hour cycle and we can make a difference within 24 hours to how a person feels.

But how is dream sleep responsible for depression?

My findings show that ordinarily dream sleep does a great housekeeping job for us. Each night it brings down our autonomic arousal level. Dreams are metaphorical translations of those waking introspections – emotionally arousing feelings and thoughts – that we don't act upon while we are awake. Once aroused, our brain has to complete that cycle of arousal and, if we don't complete it in the external world, we do so in our dream sleep. The patterns of arousal are metaphorically acted out and thereby deactivated. But depressed people do so much worrying and feel so stuck that the ruminations cause an overload of dreaming which uses up a lot of energy in the brain. They also have correspondingly less of the most physically recuperative element of sleep, so-called slow-wave sleep. Which is why they wake up exhausted and unable to focus their mind outwards and motivate themselves to get on with life.

This is a departure from the accepted view, isn't it?

Yes, it is. But we have filmed hundreds of cases and you can see time and time again that when depressed people start talking about depression, they talk about waking up tired and unable to motivate themselves. All day long they feel low and emotional. Many describe how they have difficulty getting off to sleep because of emotional thoughts going round and round in their heads. And when it is explained to them how they are doing this to themselves, the explanation alone helps – and then the therapy we do with them is primarily aimed at helping them to stop all the negative ruminating. The common explanation that their doctors give them is that there is a chemical imbalance in their brain. But that's a half-truth: the other half is that their low serotonin level is an index that their life isn't working – their needs are not being met and they feel stuck – not that they've got something 'wrong' with their brain chemistry.

Brain chemistry is not a cause, it is an effect.

So you tell your clients how they're generating their depression, then what?

We use an integrated approach combining behavioural, cognitive and interpersonal methods, relaxation, humour, suggestions for exercise – all based on what we call the "human givens", our genetic endowment of needs and resources. Any skills the person already has that can help them reconnect with other people and the wider community are particularly important. Above all, we get them to use their imagination differently, and this is not as difficult as it might seem. Our job as therapists is to stop them worrying and dreaming excessively. We do all this in the first session, and for some people that is enough. Others will need a little more work.

What exactly are the human givens?

Human givens is a phrase psychotherapists, psycho-logists, educationalists and others are increasingly using to encompass some new, large organising ideas that are developing from what science is discovering about the workings of the brain.

We are all born with a rich natural inheritance – a partially formed mind containing a genetic treasure house of innate knowledge patterns. These patterns appear as physical and emotional needs that must be met if our minds are to unfold and develop to their fullest potential. How well they connect with, unfold and become enriched by the world determines our own particular character, our clarity of perception and our own and our family's emotional health and happiness – as well as the maturity of the greater society we create around us.

In addition to emotional needs, nature has given us a range of resources to help us meet those needs in whatever environment we find ourselves in. Depression is usually caused by worry about needs not being met – needs for control, for security, for meaning, for intimacy, connection to the wider community etc. – and by misusing some of the innate resources. Worry, for example, is a misuse of one of our most powerful innate resources, that of imagination.

What other techniques do you use?

We also use metaphor and storytelling. People are used to hearing stories and anecdotes so they're not threatening. An appropriate metaphor, contained in a story, can bypass the defensiveness of the conscious mind and go in as a seed to the right neocortex, which understands patterns. Later on, when the client thinks about the therapy, that pattern in the right neocortex will fire off and makes connections spontaneously, so they have an "Aha!" experience. They can then "own" the insight, and it is easier for them to work with it.

Here's an example. A colleague's elderly client was depressed about becoming incontinent. He began telling her about his uncle and aunt who had a lovely old country house, where some of the family lived and which everybody loved. He himself used to go there often as a child. And then gradually he started to introduce the metaphor – that as the house grew older, it got damper, and there were a few damp patches and plumbing problems, but nobody seemed to mind, everybody still loved the old house and they kept bringing their families and their friends there. She came out of her depression without even having known that she had had help. This is because her brain had now absorbed a bigger metaphorical pattern which could override the one that had depressed her.

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Are there kinds of therapy that people suffering from depression would do well to avoid?

Research shows that any therapy or counselling that encourages people to introspect about what they were unhappy about in their past will deepen depression. This type of therapy is based on a misunderstanding going right back to Freud. He had a model of the unconscious mind that saw it as being very like an underground cesspit – he believed that emotions that weren't fully expressed are held onto in this cesspit of repression, and the job of the therapist is to release the noxious emotions and thereby free the person. But this just does not work. Research has shown quite unambiguously that dreams do this for us every night. In other words, nature actually invented the emotional 'flush toilet mechanism' long before Freud tried to. These kinds of approaches to therapy, by encouraging emotionally arousing introspection, are actually working against nature.

You have also ventured into one of the biggest minefields of all, psychosis, where you suggest that schizophrenia is waking reality processed by the dreaming brain. How does that work?

First you need to separate out the REM state in which dreaming occurs from the content, which is the dream. The REM state has the same characteristics as the hypnotic state – the left neocortex is generally much less activated, we have instant access to metaphor and our emotions, and we are responding to our own emotional inputs much more than we are to external reality. Now imagine someone who has been so stressed and depressed that their dreaming process has broken down – their brain doesn't properly click out of the REM state. They still have to try and make sense of the waking world but are stuck in the emotional right- hemisphere ... whose only language is metaphor. It's a frightening place to be. They are going to experience all kinds of weird things.

Such as?

Take hearing voices: left-hemisphere thoughts are still being generated in a psychotic person although they are overwhelmed by the power of the REM state that they are now largely operating out of. The only way the dreaming brain of the right hemisphere can make sense of left-hemisphere thoughts is to put it into a metaphor of 'hearing voices'. And, as in the dream state, your sense of self is dissolved because you are now acting out a dream script.

So if you are trying to process reality, you won't have a sense of self with which to orient the experiences coming in, and you're going to feel that somebody else must be controlling everything. We are not saying that this is a complete explanation for psychosis, but when it has been put to people who have experienced psychosis, they have told us, "thank goodness, that makes such sense to me".

How do all these ideas go down with the psychotherapeutic community? Are some people hostile?

When we first started it was relatively easy. We were getting people who were already open to our ideas. Later we met quite a significant bit of hostility. We'd get mass walkouts of people trained by the Tavistock Institute in London and places like that. This happens because schools of therapy tend to degenerate into ideologies and don't work with real knowledge. They become cults, with sacred texts and high priests. Then they tend not to be open to new ideas. But the encouraging aspect was the response of people at the coalface – occupational therapists, social workers, psychiatric nurses, GPs counsellors working in the community and

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so on. They knew their training didn't give them many real tools to help people. And they were totally willing to take on board new ideas and skills.

So how does the school of therapy you helped to found itself avoid becoming a cult?

Science is based on the idea that any knowledge that we currently hold is subject to revision in the light of further facts. We incorporate the latest findings from all the sciences and we accept and recognise that all the major schools of therapy have stumbled on pieces of the truth. But these are just bits of information. We don't buy into their various ideologies. Instead we look at the information and put it in a bigger model and integrate what is of value within various approaches and discard what is not. I must also say that perhaps one of the biggest bars to the advancement of therapy in Britain is the criterion used for recognising properly trained therapists. It is mainly based on ideology, not reality. For instance, research shows that it is absolutely irrelevant whether or not therapists have themselves had therapy, in terms of assessing their effectiveness, yet the British Association for Counselling and Psychotherapy (BACP) will not accredit counsellors unless they have had a minimum of 40 sessions of counselling (which they have to pay for) themselves. And some other schools of therapy require much more than that! So these power structures are more concerned with protecting their territory, how many hours training someone has had (not how effective that training is) and creating work for their members. Whereas I would say they should only concern themselves with what works and assessing how effective an individual counsellor or therapist actually is in practice.

And effective therapy is crucial given the alarming rise in mental illness. Has emotion spun out of control in our culture?

Our culture doesn't really have a handle on emotions. An emotion is simply a 'box' in which the brain initially codes incoming stimuli. So each perception is 'tagged' in the anger box, or the anxiety box, or the sadness box. Our self-obsessed culture treats emotions as though they were something sacred and the most significant aspect of being human, rather than seeing them as a primitive classification system that usually needs further refinement. Refining perceptions is the job of the higher cortex, which can fill in the thousand shades of grey that usually exists between the black and white of emotional reasoning.

Does this explain how easily we become locked in conflicts?

Emotional arousal is the hand-maiden of tyranny – in the home and on the world stage. It locks attention. It stops clear thinking and facilitates the rise of psychopathic personalities who impose their will on others. The only long-term resolution of conflict is to devise a social order that enables more people to get their needs met.

And of course, conflict, whether it is on the battlefield or in the home, can result in people becoming traumatised…

Yes. Any brain can become traumatised if put under enough pressure from life-threatening events. It is not the amount of abuse, nor the length of the time the abuse went on, that is the key factor. It's the amount of damage that has taken place to the development of personality, the failure to develop essential life skills among people who were extensively abused in childhood for example. It is when the whole of their life has become dysfunctional that there is usually a need for major long-term psychological and life-skills education. This is

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more likely when a close family member has done the abuse and thereby interfered with the unfolding of normal development.

What about victims of torture?

People who can retain an element of control during long-term torture or deprivation regimes are most likely to make a rapid recovery. Even if it is only control over when they scream – counting to ten, maybe, just before electrodes are applied. We have treated people who have experienced extreme trauma in conflicts in Eastern Europe, for example, and we found them very responsive. And we have trained a team in Northern Ireland, the Nova Project, which in the past 18 months has treated more than 300 victims of the violence from both sides of the community with amazingly good results.

How do you treat trauma?

We know that not everyone develops post-traumatic stress disorder. It is a proportion of people who are more vulnerable – very often those with good imaginations. When we are exposed to a life-threatening event, our initial reaction is to freeze to ascertain what is going on. Most of us will then activate our fight-or-flight mechanism. However, a proportion of people with good imaginations stay in the freeze state, which is essentially a hypnotic state, and an enormous amount of information from the traumatic event is programmed into their limbic system. Ever after, whenever anything at all remotely recognised as being similar to some aspect of what happened when they were initially traumatised occurs, panic and other symptoms are automatically triggered.

How do you deal with that?

We use guided imagery to produce a deeply relaxed, dissociated, trance state, then we use a technique involving the metaphor of a video, "replaying" the memories very fast to give the person control. This pulls the trauma pattern out of the limbic system into narrative memory. Of all the methods for detraumatising people we looked at this was the most effective. All the therapists we train can do this. It works because the limbic system is encouraged to replay the memories whilst the body is physiologically relaxed. This sends a different message to the amygdale, saying this event isn't dangerous any more, so it doesn't have to maintain the person in a state of hyper-vigilance. This technique will be invaluable in the aftermath of wars, which traumatise so many soldiers and civilians.

See also: www.humangivenscollege.com
and www.humangivens.com

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Basic needs checklist

To function 'properly', human beings need to meet a number of 'basic needs'. These are often taken care of by work, home life and pleasure pursuits; however depression can cause them to be impaired.

This list is given so that you can take a look at your own life to see if any area could be improved. Of course, anyone may fall down on one or two, but much more than that and you will probably be feeling the effects.

1. The need to give and receive attention

Human beings are social animals – we used to survive by being able to exist in close-knit groups, so the exchange of attention can be seen as almost as vital as food! This is why solitary confinement is seen as the ultimate punishment in today's jails. Without human contact, mental health degrades rapidly.

As depression causes you to participate less in social occasions, this need can be affected. You may also find yourself talking more about your problems to friends and family, hoping to find a solution.

While of course it is good to talk about problems to an extent, too much focus on them can put others off talking with you.

2. The need to look after the mind-body connection

This means, basically, looking after yourself. Eating regular, healthy meals, exercising appropriately, getting enough rest and relaxation. Again, this need is often impacted as depression sets in.

3. The need for a sense of safety and security

This is about knowing you will not be abused or in danger in your daily life (for example, from abusive partner), and feeling reasonably sure you are not going to lose your house, your job and so on. Worrying about safety makes it hard to attend to other needs.

4. The need for a sense of community and making a contribution

People have been shown to be healthier generally when they feel comitted to some cause, idea or group that involves more than just their own well-being.

5. The need for challenge and creativity

The human brain seems to have an innate need to create, and to absorb new information. Without an external source, the imagination can turn to creating all sorts of unpleasant scenarios, often increasing anxiety, rumination and worry, all bad for depression. The experience of being 'stretched', or using skills to their maximum in a focused way, is also an essential part of a healthy mind.

6. The need for intimacy and connection

We all need to feel that we are connected in some way to something or someone else. For some people, this can be fulfilled by a pet, but more often this needs to be another person or people. If a person cuts themselves off from others, or gets cut off by circumstances, this basic need can suffer.

7. The need for a sense of control

This is a key need, and it is obvious what happens when a person's life is controlled by others. Torture, imprisonment, violence and psychological abuse all remove control to varying degrees.

And of course, the place where we are used to having control is our own body and mind. Depression removes some of this control, as you wonder what is happening to you.

8. The need for a sense of status

Our sense of who we are, and our purpose in life, is closely connected to the sense of status we draw from having clear roles professionally – in a relationship, community or family – and having a basis for positive self-esteem and the thinking styles to enable that.

9. The need for meaning, purpose and goals

In the larger context, it is important that you have something to focus on outside of yourself, a sense that your plans for the future are worthwhile and that you can achieve them, and having beliefs and values that you hold dear and can stand up for, perhaps with others.

When a person becomes depressed, their sole goal can become to 'get rid of the depression'. They might say things like, "Once I've got rid of my depression, then I'll do X, Y or Z." This is perfectly understandable, but can worsen the situation as the person focuses on the depression more and more, to the detriment of their wider life goals.

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Frequently asked questions (FAQ)

Click on the questions to jump to the answers

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Self help for clinical depression

What is clinical depression?

'Clinical depression', as opposed to 'just' depression, is a term used to describe a collection of physical and psychological symptoms. (For every day use, they are the same thing.) If you, or someone you know, suffers from depression, it is vital that you understand what it is and how it works.

For that reason, we recommend that, to answer this question fully, you take the Depression Learning Path.

Types of depression

The popular media is packed with articles on different types of depression, which can be a bit confusing.

Clinical-Depression.co.uk deals mainly with what is known as 'unipolar' depression, where the sufferers symptoms are all depressive.

Manic depression

Manic Depression, otherwise known as Bipolar Disorder, has a much greater biological base than normal clinical depression, although psychological interventions can still be very helpful.

The manic depressive experiences extreme swings from elation and euphoria and acute depression. During the 'manic phase' they may spend recklessly and pursue wild and improbable schemes, sleeping little and often being very productive.

At the opposite 'pole', the person appears and feels lethargic, unmotivated and exhausted. In this phase the person may be unrecognizable as the same formally manic individual. The swing may take place daily or after many months at one pole.

Over time the condition often gradually becomes less severe and pronounced. Manic depression is often treated with Lithium which may be discontinued by the sufferer as he or she enters the manic phase.

Despite the more biological nature of manic depression, the information in the Clinical Learning Path will be useful, particularly the new discovery about REM sleep and depression.

Seasonal adjustment disorder

'Seasonal Adjustment Disorder', or 'SAD' is a pattern of feeling depressed during the winter months. It is most commonly treated with 'Light Therapy' whereby the person is exposed to strong artificial light every day until their symptoms lift. This can be continued throughout short daylight hour periods to keep the SAD away.

Postnatal depression

Postnatal depression (sometimes called postpartum depression) occurs in the mother in the weeks or months following childbirth. It has long been thought that this is due to hormonal changes within the mother.

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However, postnatal depression does not differ in any way to normal clinical depression. It may have more to do with a lack of adaptation to new circumstances or lack of support and social instability.

Pregnant woman who have little faith in their future abilities to provide effective care for their future babies and who feel generally ill-equipped to become mothers have a very high risk of going on to develop depression after the birth of their child.

The information in the Learning Path will be extremely useful to those suffering from, or worried about Postnatal Depression.

Is depression caused by chemical imbalance?

All emotional responses have a chemical consequence. When we laugh, for example, there is a greater amount of chemical endorphins (natural painkillers) released into the blood stream. Endorphins do not cause laughter however, they are a consequence of it.

Until recently, and partly because of drug-company marketing, the widespread belief was that depression was a biological illness. It's even been called a 'disease.'

Bear with us if you have completed the Depression Learning Path already, as you will have already read this, but it really is so important.

Depression is 10 times more common in people born since 1945 compared to people born before 1945. So, ten times as people are becoming depressed now as compared to fifty years ago (and this research takes into account increased reporting and public awareness). Biology doesn't change this fast. Genes don't alter this rapidly – so this is a clue that clinical depression and its increase are more to do with the way society and lifestyles are changing.

Depression is not an inevitable consequence of adverse life circumstances either, as only a minority of people exposed to difficult situations go on to develop clinical depression.

So what is depression if not a result of chemical imbalances – the physical symptoms are real enough!

Depression is actually a state of high arousal. Depressed people have higher concentrations of stress hormones (cortisol, noradrenaline) than non-depressed people. **(1)** The apathy and exhaustion seen in depressed people is a consequence of too much arousal, and the way the body and mind respond to this arousal.

The way we respond to situations (with thoughts of hopelessness, helplessness, anxiety, anger, etc.) effects the emotions we feel which, in turn effect the chemicals which are released.

But the emotionally aroused brain and the presence of stress hormones in turn affects how we think and feel – so it is a 'two way street'. Thoughts and emotions affect chemical composition and chemical composition affects thoughts and emotions.

So, to sum up, beating depression is not about bad things happening to us but rather how we have learned to respond to life events – good or bad.

Thyroid problems, food intolerances and other physical illness can lead to feelings of depression but less than 10% of clinical depression is thought to have a chemical basis. Appropriate psychotherapy has still been shown to be more effective than drug treatment

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alone in the treatment of chemically based depression, and far more effective in preventing relapse. By far the majority of depressions are learned phenomena not chemical ones.

To learn more about how arousal affects physiology and depression, take the Depression Learning Path.

Note

1 – Nemeroff, C. B. (1998) The neurobiology of depression. *Scientific American*, 278, 6, 28–35.

Am I likely to develop depression?

Depression knows no barriers. It affects all classes and groups. As you will know if you have completed the Learning Path, depression is more than anything else to do with the way you think about things, and how you approach life.

However, men and women have different rates of depression, which is explained by their different thinking styles and emotional makeup.

Depression in men

Over the course of a lifetime a man in Western society (USA, Europe, Australasia etc.) has about a one in ten chance of experiencing a major depression. However, a depressed man is much more likely to deal with his depression by committing suicide.

Depression in women

One in four women will experience a significant depression at some point in their lives. This statistic also accounts for reporting and awareness, which may be greater in woman.

This dramatic difference has been shown to be due to womens' different biological, sociological and psychological makeup. In general, women display greater emotional awareness than men and have a greater propensity to explore feelings, which can make for great empathy with others.

The disadvantages of being 'more in touch with your emotions' include greater rates of depression. The strategy of thinking 'why do I feel this way?' is an example of a depressing thought pattern. Women are more likely to introspect than men.

Familial depression

Depression, it appears, runs in families. It could be assumed that this is due to a genetic basis for depression, but this appears to rarely be the case. Although a small proportion of depression has its roots in biology, it is much more likely that depression running in families is due to children learning depressive strategies from their parents. **(1)**

Note

1 – Yapko, M.D. *Hand-me-down Blues*. (1999) St Martin's Griffin

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Childhood and teenage depression

This ebook contains a section devoted specifically to childhood and teen depression. However, if you are concerned about this for yourself, your child, or a friend, taking the whole Depression Learning Path will enable you to understand all about depression and how it works.

Anti-depressants

The most commonly prescribed type of anti-depressant now prescribed is the SSRI, which stands for Selective Serotonin Reuptake Inhibitor, an example of which is Prozac. These work on the levels of serotonin, a brain chemical which controls arousal levels, feelings of wellbeing, sleep and pain perception. They also, as do all antidepressants, decrease the amount of REM sleep you get, which as you will learn from the Depression Learning Path, is essential is lifting depression. (However, there are much quicker ways of doing it than with drugs.)

During depression levels of serotonin are drop as a result of over-arousal from negative introspection and lack of participation in pleasure-giving activity.

However, if after a course of anti-depressants, the person then goes back to negatively interpreting their life and what happens to them then there it is likely that at some stage, depression will return, (although the relief from suffering is of course welcome).

Most anti-depressants, if they are going to work for a particular individual, will begin to work within three weeks of starting to take them. Side effects vary from drug to drug but may include drowsiness, anxiety, and sexual dysfunction as well as insomnia.

Contrary to the impression given by some advertising, no single anti-depressant has ever been shown to be more effective than any other in lifting depression.

The Depression Learning Path contains a comprehensive review of anti-depressants and their effectiveness.

Is depression hereditary?

As you will know if you have completed the Depression Learning Path, depression is not primarily a biological disorder.

However, as we grow up, we do learn life attitudes and behavioral habits from those around us, so from this point of view depression as a way of seeing and behaving can be passed on.

However, we can also unlearn attitudes, learn new skills and become more flexible in our approach to life.

If you are concerned about this, we strongly recommend that you learn all about depression now, so you are confident in avoiding depression and know what to do if it strikes. Take the Depression Learning Path.

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How long does depression last?

The average spell of clinical depression, if left entirely untreated, will last around 8 months. During a depression, the sufferer will normally be convinced that it will never go away, but this is a classic feature of the way depression makes us think.

Certain psychotherapies can actually worsen depression, which is why it is vital that you are well informed about depression treatment. Take the Depression Learning Path.

The right sort of psychotherapy can make a great difference very quickly however. International guidelines for the treatment of depression state that a significant change should be seen within 6 sessions, or the patient should be referred elsewhere. Often, change is even quicker.

Depression and dreaming

Waking up exhausted after many disturbing dreams is a common experience for many depressed people.

It has been shown that depressed people dream up to three times as much as non-depressed people but why should this be? And does this have anything to do with feeling so short of energy first thing in the morning?

The answer is yes, it does, and we know exactly why.

The latest scientific understanding of dreams tells us that we dream for specific biological and psychological purposes.

Emotionally arousing ruminations which are unfulfilled at sleep onset (i.e. the concern is still a worry) get 'dreamed out' metaphorically during dreaming. This is done to leave the 'higher brain' (neo-cortex) free for dealing with the next day's events. **(1)**

Dreaming literally takes the 'charge' out of a concern. However dreaming is a very distinct part of sleep. It's called 'paradoxical sleep' because it is not the part of sleep which provides us with rest. During the dream phase of sleep (REM), we actually have more of the 'stress hormones' such as adrenaline in our systems.

So over-dreaming stresses the system leaving us exhausted when we awaken. If a depressed person is woken every time they show rapid eye movement (which generally coincides with dreaming) then the symptoms of clinical depression can lift. But they may become extremely anxious or manic as the negatively arousing ruminations are still occurring but no longer being 'flushed out' by the dream process.

Nature sometimes tries to prevent the person over-dreaming by causing them to awaken in the early hours of the morning so that they spend less time in dream sleep. This is known as early morning waking syndrome.

So why do depressed people dream more?

Depressed people dream more because they have more emotional arousal to 'dream out.' Depression causes (and is caused by) a lot of emotionally-arousing introspection, or rumination, that endless sort of worrying that never seems to go anywhere and just makes you feel bad.

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The importance of this discovery cannot be overstated. We now know why most of the symptoms of depression occur, and what to do about them.

If you are depressed, there are clear things you must do:

1. **Learn about depression**, so you can stop worrying about that (follow the Depression Learning Path).

2. **Get some deep relaxation** as often as you can to help your system recover from the effects of over-dreaming. (When we use relaxation techniques in our clinic, depressed people will often stay in a deeply relaxed state for up to an hour and a half, often needing to be 'woken up'. This shows clearly a missing need. They regularly report afterwards feeling 'better than they have in months'.

3. **Do anything that stops you ruminating**. This may include seeing a good therapist, who can help you get some perspective on your problems, and recommend a course of action. Depression can make things seem hopeless, in fact convince you of it, when in fact they are not. The help of a trained professional can make all the difference, as long as they use the right approach. You will learn about this on the Depression Learning Path.

Antidepressants have the effect of reducing dreaming, but as a consequence of the reduced REM, the person may then experience more anxiety or agitation. The arousal – dreaming – exhaustion cycle is not properly broken because as soon as drugs are discontinued the person then dreams even more.

Note

1 – Griffin. *Origin of Dreams*. (1998).

Which therapy is best for depression?

Whatever the therapy happens to be called, therapy for depression must incorporate the following elements:

1. A therapist who has an up-to-date and accurate clinical understanding of what depression is. (You can check this by learning yourself through the Depression Learning Path.

2. A therapy which is time-limited, active and focused on learning skills, not personality change.

3. There should be a significant improvement in symptoms within 6 sessions, and usually earlier.

4. A therapist who you feel you can work with.

There are well over 400 different types of psychotherapy on offer for clinical depression. This can be confusing to say the least.

Luckily, there has been more research into therapy for depression that any other problem, and we know exactly what works, and why.

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Therapy that works for depression, and therapy that doesn't

Well over one hundred thousand separate pieces of research have been carried out into what depression is and the most effective methods for treating it. Findings tell us that the most effective therapies for clinical depression are therapies that aim to teach skills rather than merely attempt to 'uncover' origins of and reasons for depression.

The most effective therapies are those that are 'solution-focussed' that is they seek to alleviate suffering and teach skills which can prevent future relapse.

According to the international guidelines for the treatment of clinical depression, therapy should be 'time limited' – that is to say if no improvements have occurred within six weeks of the start of the therapy the person should be referred on to another practitioner. The best combination for the treatment of depression is a combination of cognitive therapy, behavioral therapy and interpersonal therapy.

- Cognitive therapy looks at how we think and interpret events in our lives.
- Behavioral therapy looks at what we do.
- Interpersonal therapy looks at how we relate to others and how good our communication styles are.

These are all skills based therapies and have been shown to be effective with treating clinical depression. (If it seems difficult to believe that something that feels as awful as clinical depression can be caused by these things, do the Depression Learning Path and see how they affect your body and mind.)

So called psychoanalytical therapies or 'psycho-dynamic' approaches which attempt to 'go back' and discover reasons for things – focussing on what went wrong rather than building on resources are contraindicated for depression and several therapists in the USA have been successfully sued for using this approach for depression.

Depressed people often look back and mull over past hurts too much anyway, so common sense tells us that any therapy that extends this process is unlikely to be of lasting help. A depressed person may feel better in the short term when seeing a 'psycho-dynamic' therapist simply because of the support.

However, thousands of pieces of research show us that lasting symptom relief is unlikely to come from these 'pathology-focused' approaches.

Depressed people need hope, new skills and different ways of thinking to prevent future bouts of depression. It may be important to address issues from the past but the client has to become equipped and confident for living in the future.

This type of therapy has been said to cause 'Paralysis by Analysis', and will often worsen depression.

Unfortunately, many doctors, therapists and counselors are unaware of this. This may seem hard to believe, but in most countries, information travels slowly through huge health systems, and health professionals are a busy lot!

When seeking help for depression, you must be an enlightened consumer of therapy and counseling!

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What are the physical effects of depression?

Most depression is not caused by a chemical imbalance but most depression will result in a chemical imbalance. Although depressed people may seem lethargic, samples of their blood show a raised level of stress hormones such as cortisol and noradrenaline. This causes (and is caused by) over-arousal and agitation (anxiety is often a co-feature of depression) leading eventually to exhaustion and chronic fatigue. Depressed people often need to experience regular relaxation as part of their recovery.

In addition, appetite changes often accompany depression. Sufferers may eat much less than normal or much more. Likewise we may sleep less or more both of which could lead to other physical symptoms such as headaches or dizziness.

Sometimes a feature of depression is a morbid preoccupation with one's health. Constantly monitoring for symptoms can, in some people, produce symptoms. Any physical symptoms should be thoroughly checked out medically however.

There is much more on how the psychological aspects of depression lead to the physical symptoms in the Depression Learning Path.

Light therapy and depression – particularly SAD

Scientists at the Department of Psychiatry, St. Goran's Hospital, Stockholm, Sweden monitored ninety patients with major depressive disorder who were classified according to seasonal depression (60 patients of which 50 were women) and non-seasonal (22 patients of which 17 were women). All of the patients were also clinically evaluated and rated before and after morning (0600-0800) or evening (1800-2000) light treatment for ten days in a room with a luminance of 350 cd/m2 (approximately 1500 lx) at eye level. The patients' mood ratings were assessed using both the Comprehensive Psychopathological Rating Scale and the Hamilton Depression Rating Scale.

The results showed that depressed patients with **seasonal pattern** improved significantly more than those with a nonseasonal pattern suggesting a specific therapeutic effect of light treatment in depressed patients with seasonal pattern. There were no significant differences in outcome when light treatment was given in the morning or in the evening, and neither were there differences between patients with and without atypical symptoms such as carbohydrate craving or increased appetite.

Researchers at the University Hospital, State University of New York found that variability in pain intensity, demoralization and range of mandibular motion among patients suffering from myo-fascial face pain is associated with seasonal variations.

Evaluating 273 patients whose conditions were measured in each of 10 monthly interviews, the researchers found that the patients' pain intensity and demoralization were significantly greater in the peak dark months than in the peak light months.

The researchers concluded that the data suggested that myo-fascial (face) pain and depressed moods are related and may be affected by common risk factors including seasonal variations relating to the number of light hours in the day.

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Why am I depressed if my life is fine?

Sometimes, feelings of depression can seem a complete mystery. Everything in life seems to be 'in place.' A person might have supportive friends, a good job, financial security and a loving family, yet still feels unhappy or as if life is not worth living.

Regardless of a person's external circumstances, it's their *internal* ones that are important when it comes to depression. It is not simply enough to have pleasant experiences in life, you must be able to extract the appropriate emotional satisfaction for them to have the required effect!

If every time you achieve something, you think "Oh well, anyone could do that", or "I was just lucky", you are missing an opportunity. Although this may seem like a small thing, on an ongoing basis, and in conjunction with other depressive thinking styles, it can lead to a lack of meaning and self confidence.

Adapting to change

Life circumstances can change abruptly and drastically, and it is at these times that our ability to adapt is most tested. There is a natural tendency to want things to continue the way they have been, but new circumstances require new responses, and depressive thinking patterns and the resulting emotional arousal can make it difficult to adapt.

Also, if you have faced an adverse situation for a time which resulted in your feeling depressed, you may not be able to change your 'life view' once circumstances change. Habit patterns of thought can be hard to break when you don't have a clear idea of what to do. At these times, help from a appropriately trained professional can help. (Make sure it's the right kind of help though – see the Learning Path.)

Living in the past

It is common for depressed people to dwell on past times past that were not so good. 'Where did I go wrong? How could that have happened?" However understandable, this is often a dead-end. Living in the past rather than the present can maintain depression even when things are currently good. If someone is traumatized by a time which keeps resurfacing leaving residual feelings of fear then they need to find a professional who is skilled at deconditioning trauma and who understands what depression is.

Life can seem as if it is meeting all of our needs, but if you take a long hard look, is there anything that is missing? Life can seem perfect and, even if financially secure, we still have very human needs such as working towards goals, feeling connected to others in meaningful ways, the feeling that we contribute, the feeling that we are understood on an intimate level whether by friends or a partner.

A prime example of this was a man who worked very hard all his life and, at the age of fifty, retired a millionaire! He very rapidly became extremely depressed. What was missing from his 'perfect life' was that his very strong need to create and build something up was no longer being met.

He later got into Trans-Atlantic yacht sailing and started a charity which went from strength to strength. This met his needs and his depression lifted.

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Thinking styles and clinical depression

Thinking styles are so central to depression that there is a large section of the Depression Learning Path devoted to this topic.

If you suffer from depression or treat depressed people, it is absolutely essential that you understand the relationship between depressive thinking styles, emotional arousal and exhaustion.

With this knowledge, you will be able to help yourself with depression, or choose a good therapist or counselor who can help you.

Using St John's Wort for depression

St John's Wort, or hypericum, a type of herb, is often sold in capsule form in health shops and some pharmacies as treatment for mild to moderate depression. It may affect the neurotransmitters in the brain in a similar way to SSRI antidepressant drugs.

There is a significant amount of research to show that St John's Wort is effective as an antidepressant, with fewer side effects than medical drugs. However, it has been known to affect some prescribed medicines including anticoagulant drugs and the contraceptive pill so check with your medical practitioner.

Remember that using St John's Wort is still relying on an external agent to manipulate body chemistry. It is important to understand that in order to cure depression properly and prevent relapse, the skills outlined in the Depression Learning Path are essential.

Research into the use of St John's Wort to treat depression

St John's Wort was tested in a double-blind study of 105 patients suffering from mild – moderate depression. The patients were male and female , 20 to 64 years of age, and diagnosed as having neurotic depression or temporary depressive mood. They were then divided into two groups and monitored over a period of four weeks. One group were given 300mg of St John's Wort extract, three times daily, and the other group were given a placebo. All of the patients were given psychiatric evaluations before the start of the study , and after two and four weeks of treatment.

The results revealed that, after the four weeks, 67% of the Hypericum group had responded positively to the treatment without any adverse side effects whereas only 28% of the placebo group showed any signs of improvement.

The authors of the study state clearly that the study was deliberately confined to patients affected by mild forms of depression because, for those patients, the possible risks of traditional antidepressants often outweighed any expected benefits. Indeed many patients within that category were known to refuse medications because of the possible side effects. Therefore, whilst there was no evidence to suggest that Hypericum would be of any benefit to patients suffering from the more serious forms of depression, in relation to the lesser but more common forms of depression, the researchers recommend: 'Hypericum should be used as a remedy of choice'.

[Harrer. G, and Sommer.H., Treatment of Mild/Moderate Depressions With Hypericum, *Phytomedicine*, Vol. 1, 1994, pp 3 - 8.]

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St John's Wort (Hypericum) beats depression

The number of visits to alternative medicine practitioners in this country is estimated at 425 million, which is more than the number of visits to allopathic primary care physicians in 1990. Patients' use of St. John's Wort (SJW) has followed this sweeping trend. The purpose of our study was to examine the reasons people choose to self-medicate with SJW instead of seeking care from a conventional health care provider.

The researchers used open-ended interviews with key questions to elicit information. Twenty- two current users of SJW (21 women; 20 white; mean age = 45 years) in a Southern city participated. All interviews were transcribed, and descriptive participant quotes were extracted by a research assistant. Quotes were reviewed for each key question for similarities and contextual themes.

Four dominant decision-making themes were consistently noted. These were: (1) Personal Health Care Values: the patients had a history of alternative medicine use and a belief in the need for personal control of health; (2) Mood: all SJW users reported a depressed mood and occasionally irritability, cognitive difficulties, social isolation, and hormonal mood changes; (3) Perceptions of Seriousness of Disease and Risks of Treatment: SJW users reported the self- diagnosis of "minor" depression, high risks of prescription drugs, and a perception of safety with herbal remedies; and (4) Accessibility Issues: subjects had barriers to and lack of knowledge of traditional health care providers and awareness of the ease of use and popularity of SJW. Also of note was the fact that some SJW users did not inform their primary care providers that they were taking the herb (6 of 22). Users reported moderate effectiveness and few side effects of SJW.

SJW users report depression, ease of access to alternative medicines, and a history of exposure to and belief in the safety of herbal remedies. Users saw little benefit to providing information about SJW to primary care physicians.

[Wagner PJ, Jester D, LeClair B, Taylor AT, Woodward L, Lambert J Department of Family Medicine, Medical College of Georgia, Augusta 30912-3500, USA. pwagner@mail.mcg.edu]

Hypericum & depression – a review of the research

A comprehensive evaluation of the benefits and adverse effects of newer pharmacotherapies and herbal treatments for depressive disorders in adults and children was undertaken.. Literature published between 1980 to January 1998 was identified from a specialized registry of controlled trials, meta-analyses, and experts. The registry contained trials addressing depression that had been identified from multiple electronic bibliographic databases, hand searches of journals, and pharmaceutical companies. The search, which yielded 1,277 records, combined terms "depression," "depressive disorder," or "dysthymic disorder" with a list of 32 specific "newer" antidepressant and herbal treatments.

Randomized controlled trials were reviewed if they (1) were at least 6 weeks in duration; (2) compared a "newer" antidepressant with another antidepressant (newer or older), placebo, or psychosocial intervention; (3) involved participants with depressive disorders; and (4) had a clinical outcome. 315 trials that met these criteria.

Data was independently abstracted from each trial by two persons. The researchers looked at the response rate, total discontinuation rates (dropouts), and discontinuation rates due to adverse events. Response rates were defined as a 50 percent or greater improvement in

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symptoms as assessed by a depression symptoms rating scale or a rating of much or very much improved as assessed by a global assessment method.

There were 264 trials that evaluated antidepressants in patients (adults and children) with major depression. Of these, there were 14 trials evaluating hypericum (St. John's wort), and a review of these studies revealed that the herb was more effective than placebo in treating mild to moderately severe depressive disorders (risk ratio 1.9, 95% CI 1.2 to 2.8). However, the question as to whether hypericum (St. John's Wort) is as effective as standard antidepressant agents given in adequate doses was not established.

[Mulrow CD, Williams JW Jr, Trivedi M, Chiquette E, Aguilar C, Cornell JE, Badgett R, Noel PH, Lawrence V, Lee S, Luther M, Ramirez G, Richardson WS, Stamm K. Treatment of depression – – newer pharmacotherapies. *Psychopharmacol Bull* 1998;34(4):409-795]

Helping depressed friends, spouses or family members

Being around someone who is depressed can sap your energy, try your patience and put great strain on your relationship with them. Typically, all your attempts at cheering them up will be rejected.

Women with depressed husbands often feel that they are failing as wives and can become depressed themselves. Men living with depressed wives may try to help by giving advice or suggestions and become frustrated and angry when their recommendations are not acted upon.

The first thing to understand is that depression makes people behave in ways that don't fit with their normal personality.

The depression keeps them keenly on the lookout for anything that suggests that people around them don't take it as seriously as them, or for people trying to cheer them up.

You can avoid trying to cheer the person up, and even perhaps complain a little about your life to them. This can have the effect of making them feel a little less alone. You can try to convey to them that depression is a temporary state and that it is curable.

If they are able, having them complete the Depression Learning Path would be a very good idea, as it shows them what is happening to them and gives them a way forward.

Most importantly, you need to show them that you understand how bad they are feeling, and perhaps help them find professional help if appropriate. Completing the Depression Learning Path will ensure that you get the right kind of help.

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Suicide and clinical depression

It's not surprising that up to 80% of suicides are associated with clinical depression. Let's look at what clinical depression does to you:

- It leaves you with no energy, so you feel helpless in tackling tasks or problems
- It makes you feel as if things will never get better (this is called a 'stable' attributional style)
- It can make you feel physicall unwell
- It can make you feel guilty, so not only are you depressed, but you feel guilty for feeling depressed!
- It warps your memory so you feel as if your whole life has been a failure and that others would be better off without you

But remember this…

This is depression talking. It stops you from seeing things as they really are. It is if it steals your history, your present and your future, and plays them back to you painted black. Depression stops you being yourself. It stops you seeing, remembering and thinking clearly.

And depression will go away.

Think about this. If you had taken a pill a week ago, which someone said would make you feel bad for 2 months, how would you feel about the next 7 weeks? Bad, probably, but not hopeless, because you would know it was going to get better. Depression will get better too.

There is good reason for hope.

Even if you have been searching for a long time for a way to feel better, there is help. Recent advances in our understanding of depression are making it easier and easier to treat to it won't come back. If you haven't done so already, go through the Depression Learning Path. It wil take about half an hour. If you don't feel up to it at the moment, bookmark this page and come back to it when you do.

Thinking of suicide is natural when you feel trapped in a horrible and inescapable situation. It is depression that makes you feel this way.

Don't let depression cheat you and others out of the rest of your life.

If you need to speak to someone now, go to one of these depression helplines sites – there are numbers for most countries.

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Serotonin – responsible for depression?

Well not exactly, it's more like serotonin is *involved* in depression.

Serotonin is responsible for depression in the same way that food is responsible for hunger. If you have more food, the hunger will go away, but it didn't cause it in the first place!

Serotonin has come to the public's attention mostly because of the meteoric rise of SSRIs – Selective Serotonin Reuptake Inhibitors, a type of antidepressant.

However, this has led to the unfortunate and inaccurate idea that a lack of serotonin causes depression.

Serotonin is produced in the brain on an ongoing basis and in response to pleasure-giving experiences, in a normally healthy system.

But if that system becomes less than healthy, if it is depressed for example, serotonin levels can drop. But low levels didn't cause the depression!

(In a small percentage of people – estimated at less than 10% of depression cases, a low baseline level of serotonin can contribute to low mood.)

If you want to know what does cause depression, take the Depression Learning Path.

Serotonin, orgasm and SSRIs

One of the more depressing side effects of SSRIs is the inability to reach orgasm. This is because, when men or women have an orgasm, the levels of serotonin in one particular part of the brain have to drop quickly – the serotonin has to be 're-taken-up'.

But SSRIs inhibit the reuptake of serotonin – hence the problem.

Serotonin also plays a role in modulating your sleep patterns and controlling how much pain you perceive.

Less than 5% of the body's total amount of serotonin is found in the brain, the rest being distributed throughout the body. Therefore, SSRI's do not affect only the brain, by any means.

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Can exercise and meditation help depression?

It is now well known that physical exercise can alter hormone levels within the body and have a positive effect on our moods. However, new research has demonstrated that meditation offers similar benefits. Researchers at the School of Behavioural Sciences, James Cook University of North Queensland, Townsville, Australia studied the relationship between three hormones (hypothalamic pituitary adrenocortical (HPA) axis, beta-endorphin (beta-EP), corticotropin releasing hormone (CRH) and cortisol) and mood changes in 11 elite runners and 12 highly trained meditators matched in age, sex, and personality.

Despite the obvious metabolic differences between running and meditation, the researchers predicted that mood change after both of these activities would be similar if they could be associated with similar hormonal changes. Compared to pre-test and control values, mood was shown to be elevated after both activities but there was no significant difference between the two groups. There were significant elevations of beta-EP and CRH after running and of CRH after meditation, but no significant differences were seen in the increases in CRH levels between the groups. CRH was found to be directly related to positive mood changes after running and mediation. Cortisol levels were also noted to be generally high but erratic in both groups.

The researchers concluded that both running and meditation have a positive effect on our moods which is associated with the changes in relation to plasma corticotropin-releasing hormone.

[Harte JL; Eifert GH; Smith R. The effects of running and mediation on beta-endorphin, corticotropin-releasing hormone and cortisol in plasma, and on mood. Biol Psychol (NETHERLANDS) Jun 1995, 40 (3) p251-65]

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Self help for clinical depression

The first thing to realise when looking at self help for depression is that the very nature of depression can make it hard to help yourself. In this case, your best option is to get help from a trained professional.

[If you are going to go this route, take a look at the Depression Learning Path before you do so, to make sure you get someone who knows how to treat depression.]

However, if you feel up to helping yourself, here is a comprehensive list of what you need to do.

1. Get a good understanding of what depression is. Self help for depression is much more effective once you know what you are dealing with. Complete the Depression Learning Path and ensure you know clearly what is going on.

2. Regulate your sleep patterns. Get up no later than 8am and go to bed no later than 11.30pm, even if you can't sleep. If you have problems getting up in the morning, get someone else to rouse you, or have a friend call.

3. Eat three meals a day, whether you are hungry or not, at the right times.

4. Ensure you get outside early to make sure you get enough bright light to help regulate your sleep patterns.

5. Do things to occupy your mind. If you have nothing to do all day, you will tend to ruminate over your problems.

6. If you are facing a big problem, make the decision to put off thinking about it for, say, 2 weeks, or whatever is appropriate in your case. If you cannot put it off, speak to someone else who you know to be a good practical problem solver.

7. Begin a 'depression diary'. In this rate each day from 1 to 10, where 1 is the worst kind of day, and 10 the best. This will help break down the 'all or nothing' thinking that depression can cause.

8. Get as much exercise as you can. Make yourself walk briskly every day, at least. If you have any concerns about your health, see your doctor before beginning this. Research shows that exercise can lift depression.

9. Get some kind of relaxation during the day. If you know how to do meditation, self hypnosis, tai chi or some other mind-calming technique, do it. It will help reduce the physical effects of the depression greatly.

10. Start challenging your own thinking about things. If you find yourself thinking about things in a depressive way, as outlined in Thinking styles that cause depression, deliberately think in a new way. A good way to do this is to write down the original thought, then generate some alternatives.

11. Understand that depression is not part of you, it is due to a set of symptoms. These symptoms cause you to feel, think and act differently to normal. Once depression goes, things will be different. And when you have the skills to beat it, it is more likely to stay away.

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The **Depression Learning Path** from Uncommon Knowledge is a unique resource to help people learn about depression.

We have set out some basic guidelines to explain how the Depression Learning Path should be used.

Please read these guidelines carefully.

About us

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Uncommon Knowledge Ltd was set up in 1998 and is a well-established hypnotherapy center specializing in psychology training and provision of hypnosis resources online and offline.

Using the Depression Learning Path

IMPORTANT INFORMATION

The Depression Learning Path is intended to help you learn about depression and help you in your quest for optimum health and happiness. It is **not a substitute for your doctor's role** in monitoring your health.

If you are in any doubt over a health or emotional issue, you should **seek the advice of your GP or professional advisor or therapist**.

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